		1 — For State Registrar	State of Mar	yland / Depa <i>Cel</i>	artment of H	lealth and N Death		giene 004	36501
		Decedent's Name (First, Middle, La	st)				2, Date of Dea	th	3. Time of Death
Physicia	an	Frederick			14: 100		Novemb	Day Year	· Co · CM
/Medic Examin		4a. Fecility Name (If not institution, give	re street and number)		4b. City, Town, o	or Location of Deeth	1Vevemb	4c. County of De	119
100		Johns Hopkins	Huspital		Baltir	neve			
Funeral Director		1/6-22-321/	MM 2 TF	In yrs. last birthday) 75 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day Feb. 22	, Year) C	rthplece (State or Foreign Country) nnsylvania
pu »		Usual Residence of Decedent 10a. State 10b. County		Oc. City, Town or Lo	ncation				10d. Inside City Limits
ehow	5	D 4 1	'						1 ☐ Yes 2 ☒ No
the M	Director	PA PIKE 10e. Street and Number		Palmyra	Twp.			log. Citizen of What C	Country?
with De C									
ss 23	eral	HC 1, Box 120-H	12. Was Decedent Ev	erin U.S. 13	18451	Hispanic Origin? (Sp		Jnited Sta	
ter dea	Funeral	1 Never Married 2 Married	Armed Forces?	0.0.	If Yes, specify Cub	an, Mexican, Puerto	Rican, etc.)	Black, Wh	
iurs after death with the Maryle al, or tems 23a or 28s-1 eho Examiner must be notified at	by F	3 Widowed 4 Divorced	If Yes, Give	WW II	1 ☐ Yes 2🌠 No	Specity:		Specify:	White
		15. Decedent's E	ducation	16a. Dece	dent's Usual Occup	pation	. 1	16b. Kind of Busines	
nin 72 n n	Completed	(Specify only highest gri	ade completed) College (1-4or 5+)	/ife.	kind of work done DO NOT use retire	during most of work d)	ung		
d with	E O	Liententary/Secondary (5 12)	5+		& Market	ing Execu	tive	IBM	
be filed within 72 ho Ital Hygiena. Id other then "natur event, the Modical	BeC	17. Father's Name (First, Middle, Last)			18. Mother's Nam	e (First, Middle,	Maiden Sumame)	
Aenta Aenta rked tic	To E	Frederick August	Hintermiste	r		Helene S	herwood		
2 should and Men le marke aumatic	·	19a. Informant's Name/Relationship (Type, Print)	1				r, City or Town, State,	Zip Code)
1 and 2 Health em 27 ther tr		Mary Kathleen Hir	termister/W	life HC 1	Box 120	-H Paupac			
of He roth		20a. Method of Disposition 1 XBurial 2 Cremation 3 C	"Removal from State	20b. Place of Dispo cemetery, crei	sition (Name of matory or other pla		Date	20c. Location - City of	r Town, State
Pages nent of snt: If it		`4 □Donation 5 □ Other (Special		Hickory G	Grove Cem	etery 11/	19/04 W	Vaverly, P.	Α
permit. Pages 1 and 2 should be filed within Depertment of Health and Mental Hygiens. Important: if item 27 le marked other then eny injury or other traumatic event, the Mones.		21. Signature of Funeral Service Lice	CC0321	/ 22 T	2. Name and Addre	ess of Facility	anel Ir	0.0	
89589		Mancy L	Dessell	2 5	05 Churc	uneraĺ Ch h St., Ha	wley, PA	18428	
		23a. Part4. Enter the disease, or com shock, or heart failure. List only	plications that caused the one cause on each line.	e death. Do not ent	ter the mode of dyi	ng, such as cardiac	or respiratory arr	rest,	Approximate Interval Between Onset and Death
Physician		Immediate Cause (Final disease or condition							H claus
/Medical		resulting in death)	Due to (or as a c	onsequence of):		-			
Examiner		Sequentially list conditions		a) Infarct	icn				5 days
ם פ	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	consequence of):					
ecute and -trans	Examiner	that initiated events resulting in death) Last	C	consequence of):					
be axecuted ician and burial-transit		1	Due to (or as a t	consequence or).					
reate be axecuted physician and sthe burial-transit	dicai	•	d						
eath certific attending p	/Me	IF FEMALE:	23c. If yes, outcome of	pregnancy				23d. Date of d	olivon
atten for u	Physician/Me	23b. Was decedent pregnant in the past 12 months?	1 Live birth 2 4 Pregnant at tir	☐Fetal death 3☐	Ectopic pregnanc Other (specify)	у		Month	Day Year
the di	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown						
The law requires that the death certificate are has been signed by the attending phys page 2 should be detached for use as the		Part II. Other significent conditions	contributing to death but	not resulting in the u	nderlying cause gr	ven in Part I.	23e. Did to	bacco use contribute	to the cause of death?
uires sign ld be	d by						1 🗆 Y	es 2 10 10 3	Probably 4 Unknown
w require been si should b	Completed						24a, Was a	an 24b. Were	autopsy findings available
he lav	E E						autops perfor	med? prior to	completion of cause of
in: T ificat or, pa	e Cc	25. Was case referred to medical				26. Place of Deat	1 Yes		95 2 NO
scert	0 0	examiner?	Hospital:	2 ER/Outpatier	at 3 DOA Ott	ner:		ence 6 ☐Other (Sp	ecify)
eral c	n: T	27. Manner of Death	28a. Date of Injury (Month, Day)					ow injury occurred	
ath. e fun	atio	1 Natural 5 Pending 2 Accident investigation		(ear) Injury		Yes 2 No			
Atte	if	3 Suicide 6 Could not be determined	286. Place of Injury	- At home, farm, str	reet, factory, office		28f. Location (S City or Tow	treet and Number or I	Rural Route Number,
s afte	Certification;	TIOTHOUG	building, etc.	(upacity)			July of Tow	, oraro/	
To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page		(Check only 2 Medical Exe	hysician: To the best of miner: On the basis of e	xamination and/or in					
o the ithin 2 o the complet	Medical	one) 29b. Signature and title of certifier	and manner state	a.	29c. Licens	se number	2	29d. Date signed (Mo	nth, Day, Year)
F 3 ⊢ ŏ		110	yestini		Des	300			-
Ti.		30. Name and address of person who	completed cause of dea	th (Item 23a) /Tuco	Print)	200	11	Jovember 15,	200-
10				of wate		11. 2	0 2,787	7	
	te	31. Date filed (Month, Day, Year)	32. Registrar's		atreet 12	all Timera, 19	W -160	/	

DHMH 17 Rev 1/2001

Registrar

		State of Maryland / Department of Health and Mer	ntal Hygiei	2004 36502
		1- State Registrar AMEND ITEM #18 PER FH C837 169418/1694e Af Death 1. Decodent's Name (First, Middle, Last) 2.	. Date of Death	3. Time of Death
Physic			Month	Day Year 10:20 4M
/Med Exami		Tubie Harper Jr. 4a. Facility Name (If not institution, give street and number) 4b. City_Town, or Location of Death		4c. County of Death
Exam		Maryland General Hopital Traftimore Ci	ty	
Funera		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under Urear If Under 24 Hrs. 8.	. Date of Birth (Month, Day, Ye	9. Birthplace (State or Foreign Country)
Director		219-74-0943 45 Yrs. 0	4/22/195	9 Maryland
and ww	1	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location		10d. Inside City Limits
Mary!	ō	Maryland Baltimore		1 XYes 2 □ No
the I	Director	10e. Street and Number 10f. Zip Code	10g.	Citizen of What Country?
death with the Maryland me 23a or 28a-f ehow rmust be rediffed at	a D	4110 Fords Lane 21215	I	J.S.A.
deat	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specific Young), Mexican, Puerto Ric	fy Yes or No- can, etc.)	14. Race - American Indian, Black, White, etc.
36 s after	J. F.	1 Never Married 2 Married 1 Yes 2 No If Yes, Give 1 Yes 2 No Specify:		Specify: Black
0000 hours	ed by	3 Widowed 4 Divorced Year or Dates: 15. Decedent's Education 16a. Decedent's Usual Occupation	161	. Kind of Business/Industry
115- in 72	Completed	(Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired)	,	,
212 212 3 with giene.	l lie	Elementary/Secondary (0-12) College (1-4or 5+) Construction Laborer		Construction
e file othe vent,	BeC	17. Father's Name (First, Middle, Last) 18. Mother's Name (I		
/lar	2	Tubie Harper Sr. Annie TAt	um Anni	e Tatum
Maryland 21215-0036 d 2 should be filed within 72 hours att in and Mental Hygiene. It's marked other than "naturel", or treumatic event. The Medical Example treumatic event.		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Relationship)		
e, N 1 and 1 ealth 1 sm 27		Edward Harper / Brother 4110 Fords Lane, Baltimo	ore Mary	Land 21215 c. Location - City or Town, State
nt of H		1 \(\overline{X}\) Burial 2 \(\overline{C}\) Cremation 3 \(\overline{R}\) Removal from State		
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturel; or liams 23a or 28a-1 show any injury or other treumatic event, the Medical Examinational translational pages.				
Be Person		4611 Park Hgts. Ave.	'' Balti	C. Jones F/H, P.A. more, Maryland 21215
		23a. Part1. Enter the disease, or complications that valued the deeth. Do not enter the mode of dying, such as cardiac or shock, or heart failure. List only one cause on each line.	respiratory arrest,	Approximate Interval Between Onset and Death
Physician		Immediate Cause (Final disease or condition a. Ocquired Immuncatericiem	y Syr	drome
/Medical Examiner		resulting in death) Due to (or as a consequence of):	4:	
		Sequentially list conditions, if any leading to immediate b	110211	15
Ited Insit	Examiner	cause. Enter Underlying Cause (Disease or injury		
18760, cate be executed physician and the burial-transit	Еха	that initiated events resulting in death) Last c. Due to (or as a consequence of):		
8760 sate be e	dical			
68 rtifica ng ph	Med	IF FEMALE:		2
Box eath cert attendin for use	an/h	23b. Was decedent pregnant in the past 12 months?		23d. Date of delivery Month Day Year
Records, P.O. Box 6 The law requires that the death certifit the has been signed by the attending to	Physician/Me	1 Yes 2 No 9 Unknown		
P.O. that the dead by the detached		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobac	cco use contribute to the cause of death?
ds, uires uires r signa	d by		1 ☐ Yes	2 No 3 Probably 4 Munknown
w requirements	Completed		24a. Was an	24b. Were autopsy findings available
Vital Rec eicien: The law certificate has b	dmo		autopsy performe 1 Yes 2	prior to completion of cause of death? No 1 ☐ Yes 2 ☐ No
	Ö	25. Was case referred to medical 26. Place of Death (540
of Vita Phyeicien: this certific	OB	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home	e 5 🗆 Residenc	ce 6 Other (Specify)
on of ding Phye	n: T	27. Manner of Death 1 S Natural 5 ☐ Pending 28a. Date of Injury (Month, Day Year) 28b. Time of Injury Work? 28c. Injury at Work?	8d. Describe how	injury occurred
Sion endir eath. or: Af	atlo	2 Accident investigation M 1 Yes 2 No		
Division of Vital Records, for attending Physicien: The law requirest after death. Director: After this certificate has been signe in by the tuneral director, page 2 should be.	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	Bf. Location (Stree City or Town, S	et and Number or Rural Route Number, State)
Division of Vita To the Hospitel or Attending Phyeicien: within 24 hours after death. To the Funerel Director: After this certific completely filled in by the funeral director,		29a. Certifier 12 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, an	nd due to the caus	se(s) and manner as stated.
he Ho in 24 t he Fu pletely	edical	(Check only 2 Madical Exeminar: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.	d at the time, date	and place, and due to the cause(s)
To the within To the complex c	Σ	29b. Signature and little of certifier 29c. License number	29d	I. Date signed (Month, Day, Year)
^		1 /120 Momn 09540		11.11.04
7		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	1000	General Hantal
	tate	31. Date-filed (Month, Day, Year) 32. Registrar's Signature	1 land	Calcia (110) Alla
Regis		MATTER S 2001 Render & South		

State of Maryland / Department of Health and Mental Hygiene 36503 Certificate of Death Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Month Day **Physician** 5,2004 Bessie Harris /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Samaritan NA 7. Age (In yrs. last birthday, 5. Social Security Number If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Min 1 ☐ M 2 🗶 F Days 61 Director 237-70-8878 N.C. Usual Residence of Decedent 10a. State 10c. City. Town or Location 10d. Inside City Limits ir than "natural", or items 23a or 28a-f shov the Medical Examinational be notified at Director Yes 2 No Md. Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 705 Barlett Ave. 21218 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 ☐ Yes 2 🌠 No If Yes, Give 0. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: If Yes, Give Year or Dates: Specify: Black Be Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed w Department of Health and Mental Hygier Important: If item 27 is marked other th any injury or other traumatic event. If a Meadows Factory 10th grade Laborer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) William Burwell Fannie Edwards 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Samuel Burwell 705 Bartlett Ave., Baltimore, Md. Brother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) Elmwood Cemetery 11-11-04 Henderson, N.C. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Baltimore, Md. 21202 Beman March F.H. East 1101 E. North Ave. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of) Box 68760, Physiclan/Medical as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery ned by the atter 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) Yes Division of Vital Records, P.O. 9□ Unknown 9 Unknown been signed by should be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 12 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a Wasan 1 ☐ Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☑Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28c. Injury at Work? Certification: 28b. Time of 28d. Describe how injury occurred After 1 Natural 5 Pending To the Hospina C. within 24 hours after death.

To the Funeral Director: Aft 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) MICHEL KAFROUNI, HA 29b. Signature and title of certifier 29c. License number RESDOO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Loch Raven Blvd, Baltimore, MD 2/239 5601 FAFROUNI 32 Registrar's Signature State Registrar

			1 - For State Registrar			f Maryla			of He	ealth a		ental Hy	giene Reg. No		· }		504
	Physici		1. Decedent's Name	e (First, Middle	HICK!	UAN						2. Date of De Month	aath Dav	200		3. Time o	of Death
>	/Medio Examir		11	1 4	give street and nu			4b. City, To			-		1 0 5	. County of De	_		
			M EIZCY 5. Social Security N		6. Sex	7. Age (In vis	. last birthday)	If Under 1		HOR If Under 2	-	MD. 8. Date of Bi	rth	NA 9.F	Birthola	ace (State	or Foreign
	Funeral Director		247-96-3		1 M 2 X F	54	Yrs.	Months [Days	Hours	Min.	8. Date of Bi (Month, Da 5-1-	-50 Year)		Counti	S.C	
	land ow		Usual Residence of 10a. State	10b. County		10c. C	ity, Town or Lo	ocation							10	d. (nside (City Limits
	e-fsh	ctor	Md.	N	IA .		Balt	imore								1 X Ye	s 2 No
	with the	DIre	10e. Street and Nur 3323 L	mber awnview	Δυρ			10f. Zip C	ode L213				10g. Cit	izen of What USA	Count	ry?	
	death ma 23	neral	11. Marital Status	awiiview		edent Ever in I	U.S. 13.	_1			in? (Spe	cify Yes or Ne Rican, etc.)	0-	14. Race - A			
21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural; or Itema 23a or 28e-f show other traumatic event, Ite Marical Examiliar real be notified at	Completed by Funeral Director	1 X Never Marr 3 ☐ Widowed			2 XNo ve No	1	1 Tes, specify		Specify:	- Cuelto i	nican, etc.)		Black, W Specify:	Bla		
15-0	n 72 h	oletec			t grade completed)		16a. Dece (Give	dent's Usual (kind of work DO NOT use	Occupat done du retired)	ion <i>iring m</i> ost	of workin	ng	16b. K	ind of Busine	ss/Indi	ustry	
212	filed within Hygiene. other than "	omp	Elementary/Seco	, ,	College (1-4or 5+)		afateri					Bal	timore	e Ci	ity S	chools
	be filed ntal Hygie od other event, II	Be	17. Father's Name Alvin		Last)	Ma	Coy, Ji	^			's Name Leola	(First, Middle	, Maiden	Sumame)	ui.	ckman	
Maryland	should be and Mental is marked o	2	19a. Informant's N		nip (Type, Print)	ric			Street ar			l Route Numb	er, City o	or Town, State			
	1 and 2 Health a tem 27 is		David H		Sor					own C		le, Gle					061
Jore	a = =				3 Removal from	State	Place of Dispo	matory or oth	er place,			ate 20 – 04		ocation - City			
Baltimore,	교본문문		1 4 □ Donation 21. Signature of Fu		-	100	mm. Bar	2. Name and						nden, S nore, M		212	02
Ä	Depar Impor any ir	ļ., ,	▶ Bem	and D	gommon			March I				1101 E	E. No	orth Av	æ.		
			23a. Part1. Enter t shock, or hea Immediate Cause	the disease, or ort failure. List	omplications that only one cause on	caused the dea each line.	ath. Do not en	ter the mode	of dying,	such as c	ardiac o	r respiratory a	irrest,			Approxima Interval Be Onset and	tween
1,092	tificate be executed by Medical By Medical By Medical and as the burial-transit	ilcal Examiner	disease or condition resulting in death) Sequentially list confidency, leading to incause. Enter Under Cause, Classes of that initiated events resulting in death)	enditions, nmediate erlying injury s	b	(or as a conse	equence of):	5 00	nce								
P.O. Box 68	death cer e attendir od for use	Physician/Med	IF FEMALE: 23b. Was deceden in the past 12 1 □ Yes 24 9 □ Unknown	nenths?		oirth 2 ☐ Fei nant at time of	tal death 3	⊒Ectopic preg □ Other (spec						23d. Date of o		/ Jay	Year
	ss that the gned by th	by Pt	Part II. Other signi	ficant condition	ns contributing to d	eath but not re	sulting in the u	ınderlying cau	ise giver	n in Part I.		23e. Did	tobacco u	use contribute			
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Rec	e la has	Completed											psy ormed2	death	o com	pletion of	cause of
	ician: Th certificate rector, pag	Be Co	25. Was case reference examiner?	rred to medical						26. Place	of Death	1 Yes		1 U Y	95 2	!□ No	
of V	Phys this aldi	2	1 Yes 2				☐ ER/Outpatie		-	4 Nur		ne 5 Resi			pecify)		
Division of Vital	ding I. After fune	Certification:	1 Natural 2 Accident 3 Suicide	5 ☐ Pendin- investig 6 ☐ Could r	jation	of Injury oth, Day Year) of Injury - At	Injury	М		es 2□N	lo	28f. Location (·		Puml	Poute Mu	nhar
Div	To the Hospital or Attenc within 24 hours after death To the Funeral Director: completely filled in by the	Certif	4 Homicide	determ	build	ing, etc. (Spec	eify)					City or To	wn, State)			11067,
	e Hos	edical	(Check only one)	2 Medical	g Physician: To the Examiner: On the b and man	e best of my kr pasis of examir ner stated.	nation and/or in	n occurred at ivestigation, ir	my opi	nion, death	n piace, a h occurre	ed at the time,	date and	and manner I place, and d	ue to t	ted. he cause(s)
	To the within 2. To the complet	Ĭ	29b. Signature and	title of certifier	7 ~			29c. 1	License		854	1	29d. Da	te signed (Ma	nth, D	ay, Year)	1
-	6		30. Name and add	ress of person	who completed cau		30 (Type,	Print) P	١ - د	P (.	1	BaHi	4014	212	٥٧		
	Sta Regist	ate rar	31. Date filed (Mor	nth, Day, Year)	32. F	legistrar's Sigr	nature										
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			For	State of Maryland / De	•				OCEOU
			= State Registrar		ertificate of L	Jeath	Reg. I	N2004	3. Time of Death
	Physicia	an	1. Decedent's Name (First, Middle, L	.451/		HAFEZ		Day Year 2004	0835 A M
	/Medic	al -	4a. Facility Name (If not institution, g	ive street and number)	4b. City, Town, or	Location of Death		4c. County of Death	0000 H
	Examin	er	JUHNIS HOPKI		BACTIMO	OPE CITY	1	NIA	
	Funeral		5. Social Security Number 6.	Sex 7. Age (In yrs. last birthd	ay) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Yea	ar) 9. Birth	place (State or Foreign.
	Director	- 2	216-21-5521	1 M 2 OF 50 Yrs			Nov. 2, 19	954 E	24pT
	and *	-	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town o	r Location /				10d. Inside City Limits
	Aaryla f sho	5	MO Was	Do	comoke				1 Yes 2 No
	the the rough	rect	10e. Street and Number	REGIET 10	10f. Zip Code		10g.	Citizen of What Cou	intry?
	death with the Maryland ms 23e or 28e-f show	Funeral Director	701 Home	wood Dr.	211	56		Lesx	
	ems a	ner	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	 Was Decedent of Hill If Yes, specify Cubar 	spanic Origin? (Sp n, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ameri Black, White	
36	or It		1 Never Married 2 Married	I 1 □Yes 2 ☑No	1 ☐ Yes 2 No	Specify:		Specify:	/
Ö	be filed within 72 hours after death with the Marylan Ital Hygiene. Id other than "natural", or Items 23e or 28e-f show other than "natural", or Items 23e or 28e-f show evant, the Medical Example at must be notified at	ed by	3 ☐ Widowed 4 ☐ Divorced 15. Decedent's	Year or Dates:	ecedent's Usual Occupa	ation	16b	. Kind of Business/ir	ndustry
5.	n "na	piet	(Specify only highest (Secondary (0-12)	grade completed) (G	live kind of work done of le. DO NOT use retired	during most of work	ing	1 /	10
212	filed withi Hygiene. Sther than ant, 'ne M	Completed	2	College (1-401 S+)	tomemal	cer	1	Touseho	lcl
2	be file ital Hy d othe evant,	ВеС	17. Father's Name (First, Middle, La	/ / / /		18. Mother's Nam	e (First, Middle, Maid	den Sumame)	
<u>yla</u>	2 should be and Mental Is marked of aumatic eve	၉	Mohamac	Meke		Nag	10,	Meree	
<u>la</u>	and and sum		19a. Informant's Name/Relationship	[11 / 1] 70	lailing Address (Street a	and Number of Hui	al Houte Number, Cil	ty or 10wn, State, 21	7117(
Baltimore, Maryland 21215-0036	1 and Health em 2 thar		Dr. Samir Hat	EZ (HUSband) 200. Place of D	isposition (Name of		Date 20c	Location - City or T	own, State
Б	Pages nent of int: If It iry or o		1 Burial 2 □ Cremation 3 '4 □ Donation 5 □ Other (Spe	Hemoval from State	crematory or other plac	(1)	9/04 11	mor loston	Ca MD
華		1	21. Signature of Funeral Service Lie	1191110	22. Name and A dres	ss of Facility	Wine S Fren	eval Home	权
ã	permit. Departr Importa any inji	6 9	1 12 2.	8 1 N	3111 Mt. K	d. Pasad	lend Me	l. 21127	_
			23a. Part1. Enter the disease, or co	omplications that caused the death. Do not only one cause on each line.	enter the mode of dying	g, such as cardiac	or respiratory arrest,		Approximate Interval Between
	Pnysician	0.1	Immediate Cause (Final disease or condition	METASTATIC	BREAST	CAN	CER		Months.
	/Medical Examiner		resulting in death)	Due to (or as a consequence of)	:				
	Examiner		Sequentially list conditions, if any, leading to immediate	b					
	ted	Examiner	cause. Litter Underlying Cause (Disease or injury that initiated events	Due to (or as a consequence or)	•				
	al-trai	xar	that initiated events resulting in death) Last	c					
8760,	ficate be executed physicien and s the burial-transit	dicail		d					
9	tificat ng phy as th	0				-		CITATE OF THE	
Š	leath certific attending p	an/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death	3 ☐Ectopic pregnancy	,		23d. Date of delivered Month	very Day Year
. E	hed for	Physician/M	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4☐ Pregnant at time of death 9☐ Unknown	5 Other (specify)				
9.	that the de led by the a detached f	Ph		s contributing to death but not resulting in t	he underlying cause give	en in Part I.	23e. Did tobac	co use contribute to	the cause of death?
ds,	uires sign	d by	LIVER FAILUR	LE CONTRACTOR OF THE PARTY OF T			1 🗆 Yes	2 No 3 Pro	bably 4 Donknown
Division of Vital Records, P.O. Box	Attending Physiclan: The law requires that the death certific releath. octor: After this certificate has been signed by the attending I by the funeral director, page 2 should be detached for use as	Completed	SPINAL CORD	COMPRESSION			24a. Was an	24b. Were aut	topsy findings available ompletion of cause of
Re	The la te has	шо					autopsy performed	1? death?	2 No
ta	siclan: The law certificate has b lirector, page 2 s	BeC	25. Was case referred to medical			26. Place of Dea	th (Check only one)		
>	hysic his ce I direc	To E	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 ☑npatient 2 ☐ ER/Outp		- Indising in	ome 5 Residence		ify)
n o	ding Ph h. After th funeral	ion:	27. Manner of Death 1 Natural 5 □ Pending	28a. Date of Injury 28b. Tir (Month, Day Year) Inju	ury Wor	y at k? Yes 2 □ No	28d. Describe how i	njury occurred	
isio	ttend death stor: /	cat	2 ☐ Accident investiga 3 ☐ Suicide 6 ☐ Could no	the line		165 2 100	28f. Location (Stree	t and Number or Ru	ral Route Number,
<u>^</u>	in the second	Certification;	4 ☐ Homicide determin	28e. Place of Injury - At home, farm building, etc. (Specify)	, attoog table, y, office		City or Town, S	itate)	
,	Hospital or the hours afte Funeral Director tely filled in the tell fi		29a. Certifier 1 Certifying	Physician: To the best of my knowledge,	death occurred at the tin	me, date and place	and due to the caus	e(s) and manner as	stated.
. ~ 4	To the Hospital or Attending Physiclan: The within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	Medicai	one)	xaminer: On the basis of examination and/ and manner stated.					
	To the To the comp	Σ	29b. Signature and title of certifier	0	29c. Licens			Date signed (Month	
	1		> llewitz, M		, , ,	5 000	No	DVEMBER	16, 2004.
	A			to completed cause of death (Item 23a) (T	iype, Print) WOLFE ST	BAT	MORE M	0 21007	7
A	St	ate	MURTAZA KAZM 31. Date filed (Month, Day, Year)	32. Registrar's Signature	31	ا الماسيدة .	TIVE IVE	P WINDI	

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiens Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Albert Hofmann 3:40 November 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 7666 Locust Grove Road Glen Burnie Anne Arundel 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Days 1 € M 2 □ F 218-28-6338 Director <u>March 04 1933</u> Usual Residence of Decedent death with the Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Mourcal Example or institled at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☑ No by Funeral Director Maryland Anne Arundel Glen Burnie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7666 Locust Grove Road 21060 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Truck Driver Tractor Trailer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ William Hofmann Verna Griffin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7666 Locust Grove Road, Glen Burnie, MD 21060 Mary L. Hofmann (spouse) Date 17 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State * 4 □ Donation 5 □ Other (Specify) 2004 Loudon Park Cemeterv Baltimore, Maryland 21. Signature of Forestal Service Lice 1 ee Stallings Funeral Home, P.A. 3111 Mountain Road, Pasadena, MD 21122 23a. Part 1. Enter the disease, or complication shock, or heart failure. List only on is that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a conseque Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events Examiner The law requires that the death certificate be executed attending physician and for use as the burial-transi resulting in death) Last Due to (or as a consequence of). Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 4☐Pregnant at time of death 5 Other (specify) ☐ Yes 2 ☐ No been signed by the should be detached 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did toby o use contribute to the cause of death? by 1 Mes 2 □ No 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of death?

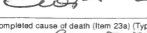
1 Yes 2 No 24a. Was an performe 1 ☐ Yes 201 To the Hospitel or Attending Physician: 25. Was case referre to medical examiner?
1 ☐ Yes 2 ☐ No Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 Residence 6 Other (Specify) Certification: To 27. Man of Death 28a. Date of Injury (Month, Day Year) the funeral 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Alter 5 Pending investigation after death. 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be within 24 hours after de To the Funerel Directo completely filled in by th 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated.

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year) NOV 1 8 2004

29b. Signature and title of certifier



29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print), 75 eA

32. Registrar's Signature

			1 - For State Registrar	State of Mary		artment of H		Mental Hygier	2004	36507
			Decedent's Name (First, Middle, La					2. Date of Death		3. Time of Death
	Physici /Medic	al	JOHN.		FORD	JR		Nov 15	Day Yeer	11,23 AM
	Examin		4a. Facility Name (If not institution, give	re street and number)		4b. City, Town, or		h	4c. County of Death	
			146 141	Sex 7. Age (In	yrs. (ast birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	WORCZ	STER
	Funeral Director		218-68-6161 -	10M 20F	4/6 Yrs.	Months Days	Hours Min.	Month, Day, Yes	1957	intry) M
	D		Usuel Residence of Decedent					1000		
	arylar show	'n	10a. State 10b. County		c. City, Town or Lo	PARKUI	110			10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	the M	Director	10e. Street and Number	LTIMORE		10f. Zip Code	"()	100	Citizen of What Cou	
	3a or	Di		OAK A	ve		21234	/	U.S. A	•
	death ms 2:	Funerai	11. Marital Status	12. Was Decedent Ever Armed Forces?	in U.S. 13. V	Was Decedent of His f Yes, specify Cubar		pecify Yes or No-	14. Race - Amer	
စ္တ	or ite	y Fu	1 Never Married 2 Married	1 ☐ Yes 2 ☐ No If Yes, Give	i	Yes 22 No		o rican, etc.)	Black, White	. •
21215-0036	within 72 hours after death with the Maryland ene. then "naturel", or items 23a or 28e-f show I.s M. dical Ex. infine fruit be natified at	ed by	3 ☐ Widowed 4 ☐ Divorced 15. Decedent's E	Year or Dates:		ient's Usual Occupa		1¢h	u	hite
7.	n "na	Completed	(Specify only highest gr	ade completed)	(Give	kind of work done d DO NOT use retired)	uring most of wor	rking	Kind of Business/l	loustry
212	filed with Hygiene ther the	Com	Elementary/Secondary (0-12)	College (1-4or 5+)		Mechan	vic		UR TIR	e CORP.
nd	be filed stal Hygierd other event, Il	Be	17. Father's Name (First, Middle, Last		SR		-	ne (First, Middle, Maid	,	
Maryland	should be and Mental marked of umetic ev	ဥ					Jean		~	
Mai	d 2 sho th and t7 Is m treum		19a, Informant's Name/Relationship MARY HALF	FORD (WIFE	780 780			Iral Route Number, Cit Balto- M		
ē	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heatth and Mental Hygiene. Importent: If item 27 is marked other then "natural; or items 23a or 28e-1 show any injury or other treumetic event, it is Madical Examinat must be muillised at once.		20a. Method of Disposition	2	0b. Place of Dispo		,		Location - City or T	
Baltimore,	Pages nent of I ant: If its ary or o		1 Burial 2 Cremation 3 C 4 Donation 5 Other (Speci			Creineros	1 11/	7/04 B	Ho. M.	
alti	permit. Page Department of Importent: If eny injury or once.		21. Inature of Funeral Service Lice	nsee + nn	22	Name and Addres	s of Facility	Tella Fun.	eral Hom	ec HTD.
	20 E 9 9	1	Mul 711	Hella	17:	521 HARF	ord Ro	. BA Its, W	21234	
Ü			23a. P. rt1. Enter the disease, or con ock, or heart failure. List only Important Cause (Final	one cause on each line.			2000			Approximate Interval Between Onset and Death
	Physician /Medical	N	di ase or condition resulting in death)	a. A CCCTC Due to (or as a co	Myoca	rdial	Linfare	tion	-	mbuom
r	Examiner				risequ-no-or):		V			
	n ä	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as a co	nsequence of):					
	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	C	annuar of).					
8760,	be ex ician burial			Due to (or as a co	nsequence or).					
687	ficate p phys ts the	edical		_ d		174				
Вох	attending for use as	In/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pr		Ectopic pregnancy			23d. Date of deliv	rery
	e death	sicla	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant at time		Other (specify)			Month	Day Year
P.O.	that the de ned by the a detached f	Completed by Physician/Me	9 ☐ Unknown Part II. Other significant conditions		t reculting in the ur	adorhina eauca anno	n in Part I	23a Did tobacc	use contribute to	the cause of death?
	ires tha signed d be del	d by	Dialettes Neello		t resulting in the di	idenying cause give	nın ranı.			bably 4 DUnknown
Sor	w requir been si should I	lete	Director ivacuo	447				24a. Was an		opsy findings available
Re	he lav e has age 2	dmc	Westing					autopsy performed?	prior to co	ompletion of cause of
Vital Records,	en: T	a	25. Was case referred to medical				26. Place of Dea	th (Check only one)	1 ☐ Yes	VACATION
Į <	Physicien: this certific ral director,	ToB	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 Inpatient	2 ER/Outpatien	t 3 DOA Othe	r. 4 Nursing H	lome 5 Residence	6 Other (Speci	
Division of	ing Pl		27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Ye	ar) 28b. Time of Injury	Work	?	28d. Describe how in	jury occurred	
isio	ttend death stor: /	icati	2 Accident investigation 3 Suicide 6 Could not to	OB Place of Injury	N/A		es 2.∏Mo	N/A 28f. Location (Street	and Number or Pur	al Pouto Number
Ď.	after Direct	Certification:	4 Homicide determined	building, etc. (S	pecify)	set, factory, office		City or Town, Sta		ar House (variber,
	ospite hours unerel ly filler		29a. Certifier 1 Certifying P	hysician: To the best of m	knowledge, death	occurred at the time	e, date and place	, and due to the cause	(s) and manner as	stated.
	To the Hospitel or Attending Physicien: The I within 24 hours after death. To the Funerel Director: After this certificate ha completely filled in by the funeral director, page	Medical	one)	miner; On the basis of exa and manner stated.	mination and/or inv					
	To To	2	29b. Signature and title of certifier	4.8		29c. License D 50 5			ate signed (Month,	
,	2,			A D	(Itam 22a) /Turn		76.	No	v. 16, 21	704
	1		30. Name and address of person who			LAIR RD	BAUTIN	NORE, MO	21236	
	Sta		31. Date filed (Month, Day, Year)	32. Registrar's S	Nienes.					
	Registr		NOV 1 8 2	004 Gener	me &	Spark	-			
DH	MH 17 Rev 1/2	001			,	//				

ORIGINAL

	•	For State Registrar		partment of Health and Me e <i>rtificate of Death</i>	Reg. No.	36508
		1. Decedent's Name (First, Middle, La	ist)		2. Date of Death Month Day	Year 3. Time of Death
hysici: Medic/		David Mathis Issa	ac		EBRUARY 8	2004 12:30 PM
xamin		4a. Facility Name (If not institution, given	e street and number)	4b. City, Town, or Location of Death	4c. Count	y of Death
		Shady Grove Adver		Rockville	Montgo	
ral tor		None	Sex 7. Age (In yrs. last birthda 1 ☑ M 2 ☐ F Yrs.		8. Date of Birth (Month, Day, Year) February 2,200	9. Birthplace (State or Foreigr Country) 4 Maryland
	-	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or	Location		10d. Inside City Limits
	5					1 ☐ Yes 24 ☐ No
	Director	MarylandMontgome: 10e. Street and Number	ry Gaithers	ourg 10f. Zip Code	10g. Citizen of	What Country?
		438 West Deer Parl	r Pond	20877		ŕ
	era	11. Marital Status		B. Was Decedent of Hispanic Origin? (Specify Cuban, Mexican, Puerto R	United S offy Yes or No- 14. Ra	ce - American Indian,
	by Fur	1 ☑ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1	If Yes, specify Cuban, Mexican, Puerto R 1 ☐ Yes 2 ☐ No Specify:	Rican, etc.) Bla	ck, White, etc. _{fy:} Black
	ed	15. Decedent's E (Specify only highest gr		cedent's Usual Occupation we kind of work done during most of working	16b. Kind of E	lusiness/Industry
	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	. DO NOT use retired)	9	
	Co	None	None None		None	
	Be	17. Father's Name (First, Middle, Last			(First, Middle, Maiden Sumai	ne)
	2	Alvin D. Mathis	1	Gwendolyn		
		19a. Informant's Name/Relationship		iling Address (Street and Number or Rural		
	-	Alvin D. Mathis Is		Vest Deer Park Road		
		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ 1 □ Donation 5 □ Other (Speci	Removal from State Gate Of	rematory or other place)	6,2004 Silve	- City or Town, State r Spring
any injury or ourse traditions event, in structure that it is a second of the second o		21. Signature of Funeral Service Lice 23a. Part1. Enter the disease, or conshock, or hear failure. List only	pplications that caused the death. Do not e		20852 respiratory arrest,	Approximate
ı.		Immediate Cause (Final disease or condition resulting in death)	a. PUL MONARY Due to (or as a consequence of):	HYPERTENSION A+RIAL-VENTRICE		Onset and Death
r			COMPLETE	A+RIAL- VENTRICO	UAN CANAL	3, 2004
	ě	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence of):		.,	FEBRUARY
	amine	Cause (Disease or injury that initiated events	TRISOMY	13		2,2004
	ω	resulting in death) Last	Due to (or as a consequence of):			
	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnancy		23d. Da	ate of delivery
	ysicia	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		B Ectopic pregnancy Discrete Other (specify)	M	onth Day Year
	Ď	Part II. Other significant conditions	contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacco use con	tribute to the cause of death?
	Completed				autopsy performed?	Were autopsy findings available prior to completion of cause of death?
	0	25. Was case referred to medical		26. Place of Death	(Check only one)	1 ☐ Yes 2 ☐ No
	ToB	examiner? 1 ☐ Yes 2 ☑ No	Hospital:	Other	ne 5 Residence 6 □Ott	ner (Specify)
	Certification; T	27. Manner of Death 1 12 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year) 28b. Time Injury	of 28c. Injury at 28	8d. Describe how injury occur	
completely filled in by the funeral	픑	E Modidatil	De Dines of Injury At house for			

State Registrar

Inez Reeves 31. Date filed (Month, Day, Year) NOV 18 2004



NEONATO LOGIST

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9901 Medical Center Drive

57942

FEBRUARY 8, 2004

			1 - For Unpend Item 23a&27 per Registrer 1. Decedent's Name (First, Middle, Last)	Cei	rtificate	e of l	Death		2. Date of Dea	th		36509
	Physici /Medic		Toni Renee Jones						NOVEMBI	ER^{1} , 2	0ď4′	2:20 P M
1	Examin		4a. Facility Name (If not institution, give street and number) 9808 LAKEPOINT CT		4b. City,		Location of	f Death		4c. County PRIN		EORGES CO
770	Funeral Director			In yrs. last birthday) 2 Yrs.	If Under Months	1 Year Days	II Under 2 Hours	Min.	8. Date of Birth Month Day NOV 6,	1972	9. Birth	place (State or Foreign intry) unk
	the Maryland 28e-f show	٥٢	Usual Residence of Decedent 10a. State 10b. County 1 MD Prince George's 1	Oc. City, Town or Lo	ocation							10d. Inside City Limits 1X Yes 2 □ No
	with the N Ra or 28e-	Direct	10e. Street and Number 9808 Lake Point Court		10f. Zip	Code 20774	<u>'</u>			log. Citizen of USA	What Cou	intry?
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Importent: If item 27 is marked other then "neturel", or items 23a or 28e-f show importent; If item 27 is marked other then "neturel", or items 23a or 28e-f show appring or other treumatic event. It is Medical Examina 1, ust be natified at once.	by Funeral Director	11. Marital Status Y Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ev. Armed Forces? 1 Yes 2 No If Yes, Give A Year or Dates:	1	Was Deced If Yes, spec		spanic Orig n, Mexican Specify:	jin? (Spe , Puerto l	cify Yes or No- Rican, etc.)		ck, White	ican Indian, .etc. lack
Baltimore, Maryland 21215-0036	within 72 hou iene, 'then "neture i're Madicul E	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	(Give	dent's Usua kind of wor DO NOT us ject M	rk done d se retired	lu <i>ri</i> ng most)	of worki	ng	16b. Kind of B		ndustry mmunication
yland 2	should be filed and Mental Hyg s marked other umatic event,	To Be C	17. Father's Name (First, Middle, Last) Arthur Jones				Patr	icia	(First, Middle, Armstea	ad		
, Mar	and 2 sho salth and n 27 is m or troum	1 2	19a. Informant's Name/Relationship (Type, Print) Mother Patricia Armstead Daniels						l Route Numbe ionsvil:			
imore	Pages 1 and the part: If item ant: If item arry or oth		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 1 Donation 5 Other (Specify)	20b. Place of Dispo cemetery, cres Oak Unio	matory or of	ther place	9)		3-04	20c. Location Albema	-	own, State Virginia
Balt	permit. Departr Importe any inji		21. Signature of Funeral Service License	22	J.F. 108 6	Bel Sth	f Fund Street	éral t Cl	Home narlott	esville	, Vi	rginia
	Pnysician	K 10	28a. Party. Enter the disease, or complications that caused the shock, of heart failure. List only one cause on each line. Immediate Cause (Final disease or condition	e death. Do not ent		e ol dying	g, such as o	eardiac o	r respiratory arr	est,		Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death) Due to (or as a continuous continu									
	cuted nd rransit	Examiner	cause. Enter Underlying	consequence of):								
8760,	icate be executed physician and s the burial-transit	dical Ex	Due to (or as a d	consequence of):								
P.O. Box 6	ath certifi attending for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of 1 Live birth 2 4 Pregnant at time 9 Unknown	Fetal death 3	∃Ectopic pre ∃ Other (spe						ite of deliventh	rery Day Year
	w requires that the deben signed by the should be detached	by	Part II. Other significant conditions contributing to death but	not resulting in the u	nderlying ca	ause give	en in Part I.		23e. Did to			the cause of death? bably 4 □Unknown
Vital Records,	The law recate has bee page 2 short	Completed							24a. Was a autops perfor	SY	Were aut prior to co death?	opsy findings available ompletion of cause of
Vita	sicien: Th certificate rector, pag	Be	25. Was case referred to medical examiner?			Othe	200		(Check only or			
of	Attending Physicien: r death, ector: After this certifice by the funeral director, t	tlon: To	1 Nanner of Death 1 Natural 5 Pending (Month, Day Y	2 ER/Outpatier 28b. Time o Injury		8c. Injury Work	at	2	ne 5 🗌 Reside 28d. Describe h			SCENE
Division	or Attendi after death. Director: A d in by the fu	Certification:	2 Cuiside 6 Could not be	- At home, farm, str (Specify)	reet, lactory	, office		2	81. Location (S City or Town	treet and Numi n, State)	ber or Rur	ral Route Number,
	To the Hospitel or Attending Physicien: The within 24 hours after death. To the Funeral Director: After this certificate hat completely filled in by the funeral director, page	edical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of examiner: On the basis of examiner and manner state	camination and/or in								
	To the within 2 To the complete	Me	29b. Signature and title of certifier		29c	O C			2	9d. Date signe		
			30. Name and address of person who completed cause of dea	th (Item 23a) (Type,	Print)	l Per	nn Sti	reet	, Baltir	nore, M	aryl	and 21201
	Sta Regist		31. Date filed (Month, Day, Year) NOV 1 8 7004 32. degistrars	Signature	mente							

KG	, 555		Stat State State Registrar		artment of Health and Martificate of Death	Mental Hygien Reg. N	2004 ANNIO
			Decedent's Name (First, Middle, Last)			2. Date of Death Month D	3. Time of Death
	Physicia /Medic	al	Joseph Johnson Sr			November	15, 2004 9:40 A M
	Examin		4a. Facility Name (If not institution, give street and	nd number)	4b. City, Town, or Location of Death	4	c. County of Death N / A
			Johns Hopkins Hospit 5. Social Security Number 6. Sex	al. 7. Age (In yrs. last birthday)	Baltimore If Under 1 Year If Under 24 Hrs.	8 Date of Birth	
	Funeral : Director		5. Social Security Number 6. Sex 214-58-6479 14 M 2	F 53 Yrs.	Months Days Hours Min.	8. Date of Birth (Month, Day, Yea Mar I 3 I	9. Birthplace (State or Foreign Country) MD
			Usual Residence of Decedent				
	uylan show	_	MD 10b. County	10c. City, Town or L Balti			10d. Inside City Limits 1 Yes 2 □ No
	8a-1 s	ecto		Baiti	10f. Zip Code	100.0	Citizen of What Country?
	h with t	ai Dir	10e. Street and Number 237 South Herring	Court	21231	Uni	ited States
036	be tiled within 72 hours atter death with the Maryland ital Hyglene. ad other than "natural", or items 23a or 28a-f show event, the Medical Examinar must be notified at	by Funeral Director	1 Never Married 2 Married 1 If Ye	Decedent Ever in U.S. ed Forces? Yes 2 No ss, Give r or Dates:	Was Decedent of Hispanic Origin? (Siff Yes, specify Cuban, Mexican, Puerton 1 ☐ Yes 2 No Specify:	pecify Yes or No- o Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: Black
20	72 ho	sted	15. Decedent's Education (Specify only highest grade compl	eted) 16a. Dece	dent's Usual Occupation a kind of work done during most of wor DO NOT use retired)	king 16b.	Kind of Business/Industry
21	within ene. then "	Completed	Elementary/Secondary (0-12) Coll	ege (1-4or 5+)	aborer	Ва	lto City Housing
2	e tiled within al Hygiene. other than '		1.2 17. Father's Name (First, Middle, Last)			ne (First, Middle, Maide	en Sumame)
land	2 should be t and Mental H is marked of sumatic eva	To Be	Joseph Clark Johns	on Sr.	Lennie	Marie T	raynham
Mary	d 2 sh th and 17 is m traum		19a. Informant's Name/Relationship (Type, Prin Christine Reed-Dau		ing Address <i>(Str</i> eet and Number or Ru 1 Eager Street	ral Route Number, City Baltimo	re, MD. 21205
Baltimore, Maryland 21215-0036	permit. Pages 1 an Department of Heal Important: If Item 2 any Injury or other once.	72	20a. Method of Disposition 1 ☐ Burial 2 □ Cremation 3 □ Removal 4 □ Donation 5 □ Other (Specify)		ematory or other place)	20	Location - City or Town, State ltimore, MD.
Balti	permit. P Departm Importar any Inju		21. Signifur of Funeral Service License	2.6	2. Name and Address of Eacility, 11 2. O. Box 11651	ams Fune: Baltimor	ral Service, P.A. e, MD. 21229
			23a. Part1. Enter the disease, or complications shock, or heart failure. List only one caus	that caused the death. Do not en	nter the mode of dying, such as cardiac	or respiratory arrest,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition		atheroscleration	Cardioves	Onset and Death
	/Medical Examiner		reculting in death)	ue to (o) as a consequence of):			
Н	Lxammer	_	Sequentially list conditions, b	ue to (or as a consequence of):			
	ted Insit	Examiner	cause. Enter Underlying Cause (Disease or injury				
Ć	execun and ial-tra	Exa	that initiated events c resulting in death) Last D	ue to (or as a consequence of):			
8760,	cate be executed physician and the burial-transit	dicai	d				
9	ntitica ng ph s as th	a a	IF FEMALE:				
.O. Box	The law requires that the death certiticate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/M	23b. Was decedent pregnant in the past 12 months?		□Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Day Year
Δ.	res that the de signed by the a be detached to	/ Ph	Part II. Other significant conditions contribution	g to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacc	o use contribute to the cause of death?
ds,	uires sign	d by				1 ☐ Yes	2 No 3 Probably ★Unknown
Records,	aw require Is been sig 2 should b	Completed				24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
Ä		mo:				10 Yes 2 □	
Vital	ysician: The is certificate hadirector, page	Be (25. Was case referred to medical examiner?			ath (Check only one)	
of \	Physician: this certific ral director,	2	XXYes 2 No Hospital	1 Inpatient 25 Ervoutpati		lome 5 ☐ Residence 28d. Describe how in	
n C	Jing Atter	ion	1 Natural 5 □ Pending	. Date of Injury (Month, Day Year) 28b. Time Injury	of 28c. Injury at Work? M 1 ☐ Yes 2 ☐ No	28d. Describe now in	ijury occurred
Division	Attending in death. ector: Atterby the fune	Certification:	3 Suicide 6 Could not be	. Place of Injury - At home, farm,		28f. Location (Street City or Town, St	and Number or Rural Route Number,
Dİ	s atter	Serti	4 Homicide	building, etc. (Specify)		City of Yowin, St	ato)
	To the Hospital or Attending Ph within 24 hours atter death. To the Funeral Director: Atter th completely filled in by the funeral	Medical ((Check only Medical Examiner: Or	To the best of my knowledge, den the basis of examination and/or d manner stated.	ath occurred at the time, date and place investigation, in my opinion, death occu	e, and due to the cause urred at the time, date	e(s) and manner as stated. and place, and due to the cause(s)
	To th within To th compl	Me	29b. Signature and title of certifier	10	29c. License number		Date signed (Month, Day, Year)
	-		Hex () to	lleras	O.C.M.E.	No	vember 16, 2004
	\cap		30. Name and address of person who complete	ed cause of death (Item 23a) (Typ	e, Print)		
			ratricia Aron	MAKA	111 Penn Street	, Baltimor	re, Maryland 21201
	St Regist	ate trar	31. Date filed (Month, Day, Year) NOV 1 8 2004	32. Registrar's Signature	& sports		

1 - For Stata Registrar Certificate of Death Rag. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Year **Physician** LOODM 200 /Medical 4c. County of Death ive street and number) 4a Facility Name (If not institution. Examiner N/A If Under 8. Date of Birth (Month, Day, Jun 23 Birthplace (State or Foreign Country) Months Days **Funeral** Hours NC Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: if Item 27 is marked other than "natural", or Items 23 or 28a-1 show any injury or other treumatic event, the Madical Examinar mans 1. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1X Yes 2 □ No MDN/A Baltimore **Funeral Director** 10g. Citizen of What Country? 10f. Zip Code 1633 North Bond Street United States 21213 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ∑ Yes 2 ☐ No 14. Race - American Indian, 11. Marital Status Black, White, etc. Black 1 Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: Specify: If Yes, Give Year or Dates: 57-65 Completed by 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Balto City Publ Sch Elementary/Secondary (0-12) 1 2 College (1-4or 5+) Janitor 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Emily Jones Joseph Price 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print, Florence Jones-Wife 21213 1633 North Bond Street Baltimore MD. Date 23 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition N2804 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Garrison Forest VA Owings Mills, MD. 4 ☐ Donation 5 ☐ Other (Specify) 21. Sig tu of Funeral Service Lipensee Cally in L. Willy iams Funeral Service P.O. Box 11651 Baltimore, MD. 21229 d. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) andrascular acciden Pnysician Para /Medical equence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner attending physician and for use as the burial-transit Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month Day in the past 12 months? 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No ate has been signed by the page 2 should be detached 9□ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 3 ☐ Probably 4 ☐ Unknown 1 Yes 2 □ No Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has 1 ☐ Yes 2**/2** No Hospitel or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Certification: Injury 1 Natural 2 Accident 5 Pending investigation after death. 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 🗀 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Thomicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) within 2 To the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier wouston (X 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3900 Loft Paven 31. Dae filed (Month, Day, Year) 32. Registrar's Signature State NOV 1 8 2004 Registrar

State of Maryland / Department of Health and Mental Hygien 2004 36512 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav **Physician** Month Knauff, 9:11 November 14, 2004 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** University of Maryland Medical
5. Social Security Number 6. Sex 7. As Baltimore Center If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1√ M 2□ F Maryland 216-14-7628 Yrs. Director Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No MD Carroll Director Sykesville 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a o any injury or other traumatic event, the Medical Expriment man ance. 707 Lee Avenue 21784 USA Funerai 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 XMarried Baltimore, Maryland 21215-0036 1 ☐ Yes 21 No Specify: White δ 3 Widowed 4 Divorced Completed 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Truck Driver Transportation 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Bruce Wilmer Knauff, Sr. Ruth Johnson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Marguerite R. Knauff (Wife) 707 Lee Avenue Sykesville, MD 21784 20a. Method of Disposition
1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Wards Chapel Cemetery 11/19/2004 Randallstown, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses HAIGHT FUNERAL HOME & CHAPEL, PA (Box 195) Sykesville, MD 21784 (410)-795-1400 CF 23a. Part1. Enter the disease, or complications the caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Preumonia Priysician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of). Examiner the attending physician and the for use as the burial-transit certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month Day 4☐Pregnant at time of death 5 Other (specify) 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, δ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖫 Unknown Acute renal failure Completed 24b. Were autopsy findings available prior to completion of cause of death? Pleural effusions 24a. Was an autopsy performed 2 🗀 No 1 🗌 Yes 2 No To the Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 ✓ Yes 2 ☐ No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 2 ER/Outpatient 3 DOA 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No s after deam. 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 | Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai (Check only one) within 2. To the (29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number P18572 November 14, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Luke Deitz Greene Street Baltimore, Maryland 21201 31. Date filed (Month, Day, Year) 32. Agistrar's Signature State NOV 1 8 2004 Registrar

1 - For State Registrar Decedent's Na

4a. Facility Name

219-34-

Usual Residence

Gil 5. Social Security

Physician

/Medical

Examiner

Funeral

Director

Ple	ase T	vpe or	Print in	Black	Indeli	ble l	nk	Fnsı	ıre Al	Il Conie	as Ar	e l en	ible	
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or tate egistrar					Certific						Reg.	20	04	36513
cedent's Name (First, Mide										2. Date of Month		Day	Year	3. Time of Death
Edward Lang										Nove			2004	
cility Name (If not instituti Gilchrist			mber)		4b. (_		ocation	of Death			4c. Count		
ial Security Number	6. Sex	TCE	7. Age (In y	re last hirth	day) If U	nder 1 Y	VSOI	l If Under	24 Hrs	8. Date of	Righ	Ва	ltim	
9-34-0595		M 2□ F	66	Yr	Mon		ays	Hours	Min.	Mar 9	Day, Ye	38	- 00	thplace (State or Foreign ountry) Iryland
Residence of Decedent				-		i			l		,		110	- I J Laria
State 10b. Coun			10c.	City, Town	or Location	1								10d. Inside City Limits
MD Bal	timor	e		Balti	more									1 ☐ Yes 21 No
Street and Number					101	f. Zip Co	ode				10g.	Citizen of	What Co	ountry?
020 Flintsh	ire R	oad			Ì		21	237				1	JSA_	
arital Status			edent Ever in	U.S.	13. Was D	ecedent	t of His	panic Or	igin? (Spi	ecify Yes or Rican, etc.)	No-	14. Ra	ce - Ame	erican Indian,
☐ Never Married 2 ☐ Ma		1 XYes If Yes, Gi	2 🗌 No		1 □ Ye	es 2X		Specify:		· muii, bio.j			ick, Whit	
☐ Widowed 4 N Divorce	d	Year or D	ates:	54-56	5	LA		Specify.				Speci	·	white
15. Decede (Specify only high	ent's Educ	ation completed)		(0	ecedent's Give kind o	of work a	done du	ion iring mos	t of work	ing	16b.	. Kind of E	Business	/Industry
mentary/Secondary (0-12)		College (1-4or 5+)	1.	ite. DO NO	OT use r	retired)							
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Informant's Name/Relation	nship (Typ	e, Print)		19b. N	Mailing Add	dress (Si	treet ar	nd Numb	er or Rura	al Route Nui	mber, Cit	y or Town	, State, .	Zip Code)
nilip Ohler/	son			57	01 Ba	ili:	ff 1	Road	Nor	th Eas	t, M	ID 2	1901	
Method of Disposition ☐ Burial 2 ☐ Cremation XDonation 5 ☐ Other		moval from		. Place of D		(Name	of	1		Date	- 1		· City or	Town, State
ignalum of Funeral Solvio Ronald	e License	ade,/	Direct	or	Stat Balt	e Ar imor	Address lato	of Facili my E MD	y 2120	1,655	W. B	altin	nore	Street
Part 1. Enter the disease, shock, or heart failure. Li ediate Cause (Final	or complic st only on	ations that	caused the de each line.		ot enter the	mode of	f dying,	such as	cardiac (or respirator	y arrest,			Approximate Interval Between Onset and Death
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entially list conditions, , leading to immediate e. Enter Underlying	J b	Due to	(or as a cons	equence of)):									
e (Disease or injury nitiated events ing in death) Last	С.	Due to	(or as a cons	equence of)):									
	d													
MALE: Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23	1 Live	tcome of prediction 2 F nant at time of	etal death	3 □Ectop 5 □ Othe						_		ate of de	livery Day Year
Other significant condi	tions con	ributing to c	leath but not	resulting in t	he underly	ing caus	se giver	in Part I	٠			o use con		o the cause of death?
										24a. W	as an utopsy orformed		prior to death?	utopsy findings available completion of cause of
lae naca referred to modify	nal .				_			00.01-		1 🗆 Ye	s 2 💢		1 L Yes	2 □ No
/as case referred to medic xaminer? □ Yes 25XNo		ospital:	Inpatient 2	! ☐ ER/Outp	atient 3[DOA	Other			h <i>(Check on:</i> me 5 □ Re		6 X Ott	ner (Spe	city) Hospia
	stigation	28a. Date (Mor	of Injury oth, Day Year	28b. Tin Inju			Injury a Work? 1 🗆 Ye	at es 2 🗆		28d. Describ	oe how in	jury occu	red	. , ,
☐ Suicide 6 ☐ Coul ☐ Homicide dete	d not be mined	28e. Place build	e of Injury - A ling, etc. (Spe	t home, farm	n, street, fa	ictory, of	ffice			28f. Location City or	n (Street Town, St	and Num ate)	ber or Ri	ural Route Number,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examinar must be notified at once. 10a. State MD To Be Completed by Funeral Director 10e. Street and N 2020 F 11. Marital Status 1 Never Ma 3 Widowed Elementary/Se 17. Father's Nam Edwa 19a. Informant's Philip 20a. Method of D 1 DBurial
4 Donation 21. Signal and 23a. Part 1. Ente shock, or h Immediate Cause disease or condi-resulting in death Pnysician /Medical **Examiner** Sequentially list of any, leading to cause. Enter Un Cause (Disease that initiated ever resulting in death Medical Certification; To Be Completed by Physician/Medical Examiner within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Linge, Edward Division of Vital Records, P.O. Box 68760, IF FEMALE: in the past 9 Unknow Part II. Other sig 25. Was case ret examiner? 1 ☐ Yes 2 27. Manner of De 1 Natural
2 Accident 3 Suicide 4 Homicid 29a. Certifier 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier November 8, 2004 25205 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Charles St. Balto and 21205 Bmc 6701 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar NOV 1 8 2004 DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** Edna M. Lamoon NOVEMBER 02 2004 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Genesis Loch Raven Towson Baltimore | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | North | Dec 12, 19 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 💢 F 67 Yrs. 212-34-6570 Director Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heath and Mental Hygiene.
neit if item 27 is marked other than "natural", or items 23e or 28e-f show ury or other traumatic event, ite Medical Earth art must be notified at my or other traumatic event, ite Medical Earth art must be notified at 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits MD Baltimore Towson 1 ☐ Yes 2♥ No by Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8720 Emge Road 21234 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ②No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: white 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) clerical banking 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Irvin Eugene Owens Lena Alma Chappell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 204 E. Joppa Road #313 Towson, MD Virginia Hileman/daughter 21286 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State t ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department o importent: if any injury or once. ¹ 4 ☑ Donation 5 ☐ Other (Specify) ronald S. Wader Dire 21. Signatura of Funeral of vice Licensee 22. Name and Address of Facility State Anatomy Roard 655 W. Baltimore Street Baltimore, MD 21201 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, for heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final BRONCHIAL OBSTRUCTION Physician disease or condition resulting in death) TWO MONTHS /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Completed by Physician/Medical Examiner resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. MULTIPLE SCLEROSIS 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed DEPRESSION 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No To the Hospital or Attanding Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After thi 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Medical Certification: Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation Diractor: / 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral D 29a. Certifier t 🔂 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of periffer 29c. License number 29d. Date signed (Month, Day, Year) 30, Name and address of person who completed cause of death (Item 23a) (Type, Print) POB #303 LOCIL RAVEN BLUD ESTNFZER QUAINCO BALTIMORE MID 32. Registrar's Signature Darkar Registrar

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State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death November Day 5, 2004 11:45a **Physician** Stella Lazewski /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner 825 Day Road Sykesville Carroll If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 10-23-1909 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 6. Sex **Funeral** Days Months Hours 1 □ M 2 € F Ukrane 95 120-28-4145 Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a State s 23a or 28a-f show 1 Yes 2 No Be Completed by Funeral Director Howard Sykesville 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 825 Day Road 21784 USA Pages 1 and 2 should be filed within 72 hours after death vinent of Health and Mental Hygiene.
ant: it item 27 is marked other than "Hetural", or Items 23, and yo other traumetic event, it... Menter Examinater : stat Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status Affied Foldes: 1 ☐ Yes 2 12 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: Specify: 3 ¼ Widowed 4 ☐ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Domestic 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) (Unknown) Krevery Molly (Unknown) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Ms. Sally Roby (Daughter) 825 Day Road Sykesville, MD 21784 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1 Department of h Important: If ite any injury or ot once. 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Crestlawn Mem. Garden's 11/20/04 Marriottsville, MD ^ 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee HAIGHT FUNERAL HOME & CHAPEL, PA (Box 195) an Sykesville, MD 21784 (410)-795-1400 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Ca diemy 0 disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause [Disease or Ir jury Due to (or as a consequ Examine the attending physicien and hed for use as the burial-transit requires that the death certificate be executed Cause (Disease or Ir jur) that initiated events restens. resulting in death) Last Due to (or as a consequence of) Box 68760 ian/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day 4☐Pregnant at time of death 5 Other (specify) Physici Division of Vital Records, P.O. 9 Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 99 1 ☐ Yes 2 ☐ **X** 6 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 🔀 No Hospitel or Attending Physician: 24 hours after death. Funeral Director: After this certifice funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 ★ esidence 6 Other (Specify) 1 ☐ Yes 2 ☐ 100 2 28d. escribe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? Certification: Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospitel within 24 hours at To the Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of pertifier ww MD 30. Name and address of person why completed cause of death (Item 23a) (Type, Print) Stoner Kus 32 Registrar's Signature 31. Date filed (Month, Day, Year) State NOV 1 8 2004 Registrar

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	/Medic Examin		4a. Facility Name (If not institution, give	street and number)	4b. City, Town, or	Location of Death	100000	4c. County of Death	.1
			NORTH ARUNDEL HOS 5. Social Security Number 6. Se		ge (In yrs. last birthday)	GLEN BU	RNIE	9 Date of Righ	ANNE ARUN	
	Funeral Director			M 2 X F	76 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, JUNE 2,	1928 MARY	place (State or Foreign ntry) 'LAND
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	and 2 ealth a m 27 Is		DEBORAH SMITH / D	AUGHTER					MARYLAND 2	
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ı	Physician		Immediate Cause (Final disease or condition	my		*				Tion			Onset and D	Death
	/Medical Examiner		resulting in death)	Due to (or as	a consequence of):								S 10 .	
		Je.	Sequentially list conditions, if any leading to immediate		a consequence of):							-	- IUY	K)
15	ut ēď d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underfying Cause (Disease or injury that initiated events	NA	netes	Me	LLIT	TUS	T	1/e 11			>100	yJ.
,097	i be executêd sician and burial-transit		resulting in death) Last	Due to (or as	a consequence of):									
	9 % 9	dical	d											
ox e	leath certific attending pl	Physician/Med	IF FEMALE:	Bc. If yes, outcome	of pregnancy						234	Date of delive	an/	
Bo	death e atten d for u	ician	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	4☐Pregnant at		B □Ectopic p Double of the control						Month	*	ear ear
0.	if the c by the tacher	hys	9 Unknown	9□ Unknown										
Records, F	The law requires that the death certifica ste has been signed by the attending ph page 2 should be detached for use as th	Completed by P	Part II. Other significent conditions con	tributing to death bi	ut not resulting in the	underlying	ause give	en in Part I	•	23e. Did to			he cause of de pably 4 □U	
Ö Ö	aw require is been sig 2 should b	piete	* * *							24a. Was a		b. Were auto	psy findings a	available
	sicien: The law certificate has b irector, page 2 s	Com		-						autops perfor	ned? No	death?	mpletion of ca 2□ No	luse of
Vital	cien: ertifica ector,	Be (25. Was case referred to medical examiner?				0.1			(Check only or	10)			
	iding Physicien: th. After this certifica funeral director, p	<u>۲.</u>	1 Yes 2 No	ospital: 1 ☐ Inpatie 28a. Date of Inju			Othi 28c. Injury	4 🗀 NU	7.7	me 5 Reside			y)	
O	ding h. After funer	tion	Natural 5 Pending 2 Accident investigation	(Month, Day			Worl	k? Yes 2⊟		zod. Describe III	ow injury occ	Surred		
Division of	the the	ifica	3 Suicide 6 Could not be determined	28e. Place of Inju	ury - At home, farm,	street, factor	y, office		:	28f. Location (S		mber or Rura	l Route Numb	ber,
ā	tal or	Certification;	4 - Homeda	building, etc	с. (Зреспу)				J.	City or Town	1, State)			
	To the Hospital or Att within 24 hours after d To the Funeral Direct completely filled in by	Medical	29a. Certifier (Check only one) 1. Certifying Phys 2 Medical Examin	icien: To the best of er: On the basis of and manner sta	examination and/or	ath occurred investigation	at the tin , in my o	ne, date an pinion, dea	nd place, a oth occurr	and due to the c ed at the time, d	ause(s) and ate and plac	manner as s e, and due to	tated. the cause(s)	1
	To the To the comp	Σ	29b. Signature and title of certifier	A har	1	29	c. License	e number		2	9d. Date sig	ned (Month,	Day, Year)	
!	I_{f}		ZY WHO	m 1" b	eath (Item 92-) 57	o Deina	Ul	75	03)	1-	16-	04.	
	10		30. Name and address of person who con Edward P. Costlow				ard	Ave	ç,	uite 214	Time	nnium	MD	
	Sta	ate	31. Date filed (Month, Day, Year)	32. Registra	ar's Signature	Spa	u u	/ . v C .	,)	115 414		471 14111	_LIVI	
	Regist	rar	NOV 1 8 2004	Street	na p	spo	chi?							

		•	For State Registrar	State of Maryla		artment of H			giene Reg. Noc	2004	36520
	۰	74	Decedent's Name (First, Middle, Last)	1				2. Date of De	ath		3. Time of Death
	Physici /Medic		SARAH ELI	ZABETH LE	ENERT			Month	Day	16 2004	10:509 M
	Examin		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, or	Location of De	eath	4c.	County of Death	
			STELLA MARIS HOS		ERCY	BALTI				N/A	
	Funeral Director	- 1	5. Social Security Number 6. Sec. 212-34-4871	7. Age (<i>ln yr</i>	s. last birthday) Yrs,	Months Days		in. 8. Date of Bir (Month, Da FEB. 2	th y, Year)	COL	place (State or Foreign intry) NTUCKY
	TO.		Usual Residence of Decedent		-:-						
	anylar show	_	10a. State 10b. County	106.0	City, Town or Lo						10d. Inside City Limits 1 ▼Yes 2 □ No
	88-f	Directo	MD. N/A		BALTI				10 001		
	a or 2	급	10e. Street and Number	7 (7 T) N I I I T)		10f. Zip Code				zen of What Cou	intry ?
	s 23	eral	418 N. MILTON	AVENUE 12. Was Decedent Ever in	U.S. 13	Was Decedent of H		(Specify Yes or No		U.S.A. 14. Race - Amer	ican Indian
•	r Iten	Funeral	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☐ No				(Specify Yes or No lerto Rican, etc.)		Black, White	
215-0036	al', o	by	3 NVidowed 4 Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 🔀 No	Specify:			Specify: WH.	ITE
ည	72 ho	Completed	15. Decedent's Edu (Specify only highest grad		(Give	dent's Usual Occup	during most of v	working	16b. Kir	nd of Business/I	ndustry
2	nithin 36. han	mple	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retired	4)	•	TID		AT
2	be filed within 72 hours after death with the Maryland ital Hygiene. Id other than "natural", or items 23a or 28a-f show event, the Medical Examinat must be realified at		17. Father's Name (First, Middle, Last)	4	1 E	ACHER	18 Mother's N	Name (First, Middle		UCATIO	N
anc	e d al be	Be	JOHN JOHNSON					THA ROSE			
2	2 should be filed and Mental Hygid Is marked other aumatic event, II	ဥ	19a. Informant's Name/Relationship (Ty	voe. Print)	19b. Maili	na Address (Street		Rural Route Numb			p Code)
Maryland 21	nd 2 s Ith ar 27 Is r trau			JGHTER							LAND 21224
	s 1 and 2 should of Health and Men item 27 Is marke other traumatic	1 3	20a. Method of Disposition	20b	. Place of Dispo	osition (Name of matory or other place		Date		cation - City or T	
Ê	00 0		1 ∑Burial 2 ☐ Cremation 3 ☐ F `4 ☐ Donation 5 ☐ Other (Specify)	lemoval from State	-	OF FATI		20/04	BAL	TIMORE	MARYLAND
Baltimore,	permit. Pag Department Important: f any injury o		21. Signature of Funeral Service Licens		2	2. Name and Addres	ss of Facility ZEILEI	R INC. F	'UNE	RAL HO	ME
			23a. Part1. Enter the disease, or compl shock, or heart failure. List only or	ications that caused the de						AUIIMOI	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	le cause on each line.	do	e. tin					Onset and Death
	/Medical		resulting in death)	a Due to (or as a cons	equence of):						
	Examiner		Sequentially list conditions	0							
	p #	Iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a cons	equence of):						
	ecute and -trans	Examiner	that initiated events resulting in death) Last	c Due to (or as a cons	naucano of):						
8760,	ate be executed hysician and the burial-transit	三田		Due to (or as a cons	equence on).						
	ate hy:	dlcal		d							
Box 6	The law requires that the death certific the has been signed by the attending page 2 should be detached for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of preg					2	23d. Date of deliv	rerv
	death a atter	iciai	in the past 12 months?	1 Live birth 2 Fe 4 Pregnant at time o		⊒Ectopic pregnancy □ Other (s <i>pecify</i>)	<u> </u>			Month	Day Year
o.	t the c	hys	9 🗆 Unknown	9□ Unknown							
S, P	s tha	by P	Part II. Other significant conditions co.	ntributing to death but not r	resulting in the u	inderlying cause giv	en in Part I.	23e. Did t	obacco u	se contribute to	the cause of death?
ğ	w require been sig should b							_ 1 🗆	Yes 2	□No 3□Pro	bably 4 DUnknown
Record	e law requ has been je 2 shoul	Completed						24a. Was		24b. Were aut	opsy findings available ompletion of cause of
ř		Som						perfo 1 ☐ Yes	ormed? 2 ☑ No	death? 1 ☐ Yes	
Vital	ician: Th certificate rector, pag	Be (25. Was case referred to medical examiner?					Death (Check only o			
7	Physic this c	မ	1 ☐ Yes 2 € No	Hospital: 1 ☐ Inpatient 2	11	The second second	er: 4 🗌 Nursin	g Home 5 Resi			by hospice
N C	ling F	lon	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year,	28b. Time of Injury	Wor	yat k? Yes 2 ⊟No	28d. Describe	now injury	y occurred	
<u>S</u>	or Attending Physician: after death. Director: After this certific in by the funeral director,	icat	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Injury - Al	t home farm et		192 5 140	28f Location (Street and	d Number or Rur	al Route Number,
Division of	l or A after Direction by	Certification	4 Homicide determined	building, etc. (Spe	ecify)	reet, ractory, office		City or To			ar rioute runnest,
	To the Hospital or Attending Phwithin 24 hours after death. To the Funeral Director: After the completely filled in by the funeral	edical C	(Check only 2 Medical Exami	sician: To the best of my kiner: On the basis of exam	knowledge, deal	th occurred at the tin	ne, date and pla pinion, death o	ace, and due to the	cause(s) date and	and manner as : place, and due !	stated. to the cause(s)
	To the k within 24 To the R complete	Med	29b. Signature and title of certifier	and manner stated.		29c. Licens				e signed (Month,	
	To wit		200. Signatura and title of certifier	~		1 11	DOCL		11	161	2009
			20 Name and addition	Analoted course of death (tom 22a) /T	Print\	USSEL				
	O		30. Name and address of person who or David Rischer	201 54 0	C. II PI	0 1 1	Morce	md. E	120	2	
	St	ate	31. Date filed (Month, Dav. Year)	22. Registrar's Sig	400	1					
	Regist		MUN 1 8 2004	serva	As in	400ils					

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav Year Month **Physician** Maxie Linkous 3:50 PM November 6, 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Suburban Hospital Montgomery

9. Birthplace (State or Foreign Country) Bethesda If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Hours 1 □ M 2 🖾 F Director 212-38-0898 64 Jan 28, 1940 Tennessee Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits nit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan satment of Health and Mental Hygiene. orients: if Item 27 is marked other than "natural; or Iteme 23e or 28e-f show injury or other traumatic avent, the Medical Extra-line mast ke notified as MD Montgomery Kensington 1 ☐ Yes 2√ No **Funeral Director** 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 10231 Carroll Road 20895 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 📉 No If Yes, Give Year or Dates: t Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No Be Completed by Specify: white 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12 College (1-4or 5+) clerk clothing store 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Park Linkous Sarah Jane Lipe 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lillian Pace/sister 415 Cavesprings Road Rogersville, TN 37857 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Importent: If any Injury or * 4 ☐ Donation 5 🙀 Other (Specify) 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street
Baltimore, MD 21201 21. Signature of Euneral Service Licensee Ronald S. Wade mul Enter the disease, or complications that caused the react failure. List only one cause on each line. or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** sepsis /Medical Due to (or as a consequence of): **Examiner** pneumonia Sequentially list conditions, Examiner Due to for as a constituence of cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed the burial-transit lung cancer the attending physician and Due to (or as a consequence of): Physician/Medical as esu. IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnancy jo in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4 Pregnant at time of death 5 Other (specify) 9 Unknown es been signed by 2 should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 50 þ 2 No 3 Probably 1 ☐ Yes 4 DUnknown Be Completed 5 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy performe 2 No 2 No 1 TYes 1 Yes the Hospitel or Attending Physicien: 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ☐ ER/Outpatient 3□ DQA 28a. Date of Injury (Month, Day Year) Mann of Death Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Matural Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident within 24 hours after death To the Funerel Director: the 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Wa 4 Homicide AAXII 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) LINKOUS 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Mame and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) mon 32. Registrar's Signature 8 2004 NOV 1 Registrar

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

			1 - For State Registrar	State of Ma	aryland /	-	artment of tificate o			Reg.	7111) 4	36522	2
П	Physicia		1. Decedent's Name (First, Middle, I						Mon		Day	Year	3. Time of Death	м
	/Medic Examin	al	Baby Boy Lewi				4b. City, Town	, or Location of		ember	4c. County	of Death	14:450	-
	Examin	er	The Johns Hon	Cincs Hes	stial		Batt	i more	e Cit	4				
	Funeral Director		5. Social Security Number 6 none	.Sex 7. Åg 1 ☑ M 2 ☐ F	e (In yrs. last	birthday) Yrs.	If Under 1 Year Months Day		Min. (Mor	of Birth oth, Day, Ye 5, 20	ar) 04	9. Birthp Coun Mary]		gn
	put *		Usual Residence of Decedent 10a, State 10b, County		10c. City, T	own or Lo	cation					1	Od. Inside City Limit	ts
	Maryla f sho	tor	MD			Balt	imore						1★ Yes 2 N	
	r 28a-	Irec	10e. Street and Number				10f. Zip Code)		10g.	Citizen of W	hat Cour	try?	
	23a c ust be	a D	709 Kenwood Ave	nue				21205			U	SA		
<u>36</u>	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "neturel", or Items 23a or 28a-f show any injury or other traumatic event. I're Medical Examinar most be notified at once.	Completed by Funeral Director	11. Marital Status 1 ☑ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces? 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates:		i	Was Decedent of Yes, specify Cu I ☐ Yes 2🗓 N		in? (Specify Yes Puerto Rican, e	or No- tc.)	Black	e - Americ k, White, : bla	etc.	
Maryland 21215-0036	in 72 hou n neture Modical E	pleted	15. Decedent's (Specify only highest (Elementary/Secondary (0-12)	Education		(Give	dent's Usual Occ kind of work dor DO NOT use reti	ne durina most	of working	16b	. Kind of Bu	siness/Ind	lustry	
21	filed within Hygiene. other than one.	Com	none	none		none_					one			
Ind	be file	Be	17. Father's Name (First, Middle, La	st)			un	r.	's Name (First.)		den Sumame	θ)		
<u> </u>	should be nd Mental marked c	ဥ	19a. Informant's Name/Relationship	(Type Print)		19b. Mailir	ng Address (Stre		ae Lewi		tv or Town.	State. Zip	Code)	
Ma	and 2 sho ealth and n 27 Is m		Johns Hopkins						t Balti			1287	ŕ	
Baltimore,	permit. Pages 1 and 3 Department of Health Important: If item 27 any injury or other tra		20a. Method of Disposition 1	□Removal from State	ceme	e of Dispo etery, crer	sition (Name of natory or other p	elace)	Date	20c	Location - (City or To	wn, State	
Balti	permit. Departn Importa any inju		21. Signature of Funeral Service Lice Ronal	wade, pr	ector	4	Name and Add ate Ana altimore		bard 655 21201	W. B	altimo	ore S	treet	
	Physician		23a. Part 1. Enter the disease, or or shoot, or heart failure. List or Immediate Cause (Final disease or condition resulting in death)	a. Fluit	ne.		. 93		92 0000		BANG	16	Approximate Interval Between Onset and Death ON & Day	/
	/Medical Examiner		III P. CO. L. GOOGLOOGICA DANGADA	Due to (or as	a consequen	ce of):	REMA	turi	te Dis YV			Z	WEDAY	
8760,	certificate be executed adding physician and use as the burial-transit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): C. Due to (or as a consequence of): Due to (or as a consequence of): d.									7			
O. Box 6	death certific e attending p ed for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant a 9 □ Unknown	2 Fetal de	ath 3]Ectopic pregnar] Other <i>(specify)</i>				23d. Date Mor	e of delive	ry Day Year	
rds, P.	sign sign d be	by	Part II. Other significant condition SEVERE JUH	s contributing to death b			nderlying cause Hemo I	given in Part I. RRhAQ	23E	i. Did tobacc	10	ribute to th	e cause of death?	۷N
Vital Records,	The ate has page	Completed								. Was an autopsy performed Yes 2	l? P	Vere auto prior to con leath? Yes	osy findings availab npletion of cause of 2000 No	le f
Vita	Physicien: The this certificate ral director, pages	Be	25. Was case referred to medical examiner?	Hospital:				Othor	of Death (Check					
of	Phys rat dii	To I	1 ☐ Yes 2 🕅 No 27. Manner of Deat	28a. Date of Inju	ıry 28	Outpatier b. Time o	28c. In	iury at	rsing Home 5 28d. Des		e 6 □Othe		′)	
on	nding the	atlon	1 Natural 5 ☐ Pending 2 ☐ Accident investiga	(Month, Da	ıý Yəar)	Injury		vork? □Yes 2□N	10					
Division	Hospitel or Attending 44 hours after death. Funerel Director: After tely filled in by the fune	Certification:	3 Suicide 6 Could no 4 Homicide determin	ad 286. Place of III	jury - At home tc. <i>(Specify)</i>	e, farm, str	eet, factory, offic	се	28f. Loca City	ation (Street or Town, S	t and Numbe tate)	er or Aura	l Route Number,	
	To the Hospitel or Ai within 24 hours after of To the Funerel Direc completely filled in by	edical C		Physician: To the best caminer: On the basis of and manner st	of examination									
١	To the within 2 To the complet	Σ	29b. Signature and title of certifier	7				ense number			Date signed	•	*	
,			How		donath /lto= 00	1	D KES	5-000	0	NOU	IEMBE	ER 6	2004	
			30. Name and address of person w	SOM MI	Jean (Item 23	O M	orth wir	IFE St	REFT. B.	9/4/1	CRE .	MI	2004	
	Sta Regist		31. Date filed (Month, Day, Year) NOV 1 8 200		rar's Signature	y,	Sparks	/						

			1 - For Amend Items State 25, Maryland / Personal Registrar 1. Decedent's Name (First, Middle, Last)	Ce	tificate of	Death	2. Date of D	eath		3. Time of Death	
	Physicia /Medic Examin	al	Eugene Mosby 4a. Fecility Name (If not institution, give street and number)		4b. City, Town,	or Location of			Year 9, 2004 County of Deat	11:45 AMM	
	Funeral Director	er	Heartland of Hyattsville 5. Social Security Number 5.77-38-9569 6. Sex 1X M 2 F 7. Age (In yrs. last to 1) Age (In yrs. l	ointhday) Yrs.		sville		Pr	ince Ge	_	
	deeth with the Maryland ms 23a or 28a-f show	ctor	Usuel Residence of Decedent 10a. State 10b. County 10c. City, To		ille					10d. Inside City Limits 1 ☐ Yes 2 ☐ No	
	with the	i Director	10e. Street and Number 6500 Riggs Road		10f. Zip Code	20783		10g. Citi	zen of What Co USA	ountry?	
	be filed within 72 hours after deeth with the Marylan Hygione. d other than "natural", or items 23a or 28a-f show event, the Madical Examinal related be notified at	by Funerai	11. Marital Status 1			Hispanic Origi ban, Mexican,	in? (Specify Yes or N Puerto Rican, etc.)	10-	14. Race - Ame Black, White Specify: b1	e, etc.	
Maryiand 21215-0030	filed within 72 hours after Hygiene. ther than "natural", or ite ent, the Madical Exertine	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	a. Dece (Give life.	dent's Usual Occi kind of work don DO NOT use retir	e during most red)	of working		nd of Business/	industry rtation	
חם ג	be filed that Hygie od other if	Be Co	17. Father's Name (First, Middle, Last)		Cab dill		's Name (First, Middl			unk	
Z A	should be and Mental Is marked o	To	Joseph W. Mosby 19a. Informant's Name/Relationship (Type, Print) 15	b. Maili	ng Address (Stree	at and Number	or Rural Route Num	ber, City o	r Town, State, 2	Zip Code)	
	ges 1 and 2 should t of Health and Men if Item 27 is marke or other treumatic	1	Gloria Watson/sister	101	07 Scoto		Drive Lar	go, l	MD 2077	4	
Baltimore,	permit. Pages 1 Department of Hi Important: If Iter any injury or ott		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State '4 ☐ Donation—5 ☑ Other (Specify) in state	ery, crei	esition (Name of matory or other pl	į	Date		ecation - City or		
eg D	Depig Impe		21. Simulate of Euneral Service Licensee Ronal Id S Wards Vargetor		ate Ana I ti more		ard 655 W	. Bal	timore	Street	
	Physician /Medical Examiner	100	23a. Pert Lenter the disease, of complications that caused the death. Do shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, any leading to immediate cause. Enter Underlying Cause (Disease or injury)	n in		35				Approximate Interval Between Onset and Death	
	ficate be executed physician and s the burial-transit	edicai Examiner	that initiated events resulting in death) Last Due to (or as a consequence of): d								
O. BOX	The law requires that the death certificate are been signed by the attending phy page 2 should be detached for use as the	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 9 ☐ Unknown		Ectopic pregnan Other (specify)	су			23d. Date of del Month	ivery Day Year	
rds, P.	w requires that the de been signed by the should be detached		Part II. Other significant conditions contributing to death but not resulting colon cancer renal failure	in the u	nderlying cause g	iven in Part I.			se contribute to	the cause of death?	
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Ž D	tel or Att s after d al Direct ed in by	Certif	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, building, etc. (Specify)	farm, st	eet, factory, office	Э	28f. Location City or To	(Street an own, State	d Number or Ru)	ural Route Number,	
	To the Hospitel within 24 hours a To the Funeral i completely filled	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowled 2 Medical Examiner: On the basis of examination a and manner stated.	ge, deat and/or in	h occurred at the vestigation, in my	time, date and opinion, death	place, and due to the occurred at the time	e cause(s) e, date and	and manner as place, and due	stated. to the cause(s)	
	within To II	Σ	29b. Signature and title of certifler		29c. Lice	nse number	7		e signed (Monta		
			30. Name and address of person who completed cause of death (Item 23a					001-		-	
	Sta Registi		Nasreen Kango, M.D., 4610 Carrol1 31. Date filed (Month, Day, Year) 32. Registrar's Signature	Ave	e. , #205	Takoma	Park, Md 2	U912			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 2 0 14 36524 February From #10b&d PER FHC837 G97#18349 of Peath 2. Date of Death 3. Time of Death **Physician** ovem Ba 200 16 /Medical 4a. Fecility Name (If not institution, give street and number) 4b. 4c. County of Deeth City, Town, or Location of Death Examiner 6 50 A ImoRe 8. Date of Birth (Month, Day, Sex/ Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) **Funeral** Days Months Hours Min Q Director 0 Usual Residence of Decedent filed within 72 hours after deeth with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show other traumatic event, the Medical Examiner must be notified at TUYES 2XX Director BALTO Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or iteme 23a Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No 11, Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Newer Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Specify 3 ₩Widowed 4 Divorced Specify: natural', 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Department of Health and Mental Hygiene Important: If item 27 is marked other then eny injury or other traumatic event, Ita Ms 00.00. College (1-4or,5/+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame. Be Pages 1 and 2 should be 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11(lightr 20b. Place of Disposition (Name of cometery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 Removal from State 4 □Donation 5 □Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Greene Funeral 23a. Part1. Enter the disease, or complications that caused the death, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onget and Death Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final **Physician** disease or condition 7/10 /Medical resulting in death) Due to (or as Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Completed by Physician/Medical Examiner use as the burial-transit or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last signed by the attending physician and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 DEctopic pregnancy be detached for in the past 12 months? Month Year 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 1 Yes been 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death? certificate has 2 □ No 1 ☐ Yes 2 ☐ No 1 Yes 25. Was case referred to medical examiner?
1 Yes 2 No Certification: To Be 26. Place of Death (Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 ☐Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA \$118 To the Funeral Director: After the completely filled in by the funeral 27. Mail er of Death 28a. Date of Injury (Month, Day Yeer) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural death. 1 🗌 Yes 2 🗆 No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after To the Funerel Direct 4 Homicide Hospitel 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a, Certifier (Check only one) and manner stated. To the 29b. Signature and 29c. License number 29d. Date signed (Month, Day, Year) No vem BER 30. Name, and address of person who completed cause of death (Ite 1 24) (Type, Print) Somm Year) 31. Date filed (Month, Day, 32. Registrar's Signature

DHMH 17 Rev 1/2001

State Registrar

NOV 1 8

			Please 1 1 - For For Registrar	State of Maryland	l / Depa		Health and M	lental Hyg	giene	.egible.	36525	
	Physic /Medi		1. Decedent's Name (First, Middle, Last SR . ELLEN MCF	HENRY, M.H.S.H				2. Date of Dea Month Noveme	th Day	Year	3. Time of Death	
	Examir Funeral		4e. Fecility Name (If not institution, give THE VILLA 5. Social Security Number 6. Se	x 7. Age (In yrs. Ia	st birthday) Yrs.			8. Date of Birth	Ba	4004		
	Director -I e how I lied at	tor	Usuel Residence of Decedent 10a. State 10b. County Maryland Baltimore		Town or Lo	ers Forge		Nov 14,	192	L Ne	W York 10d. Inside City Limits 1 □ Yes 2 ☑ No	
	h with the	al Director	10e. Street and Number 6806 Bellona Aver			10f. Zip Code	1212		10g. Citize	en of What Co	untry?	
920	be liled within 72 hours after death with the Maryland Hygione. A Hygione. A other than "natural", or items 23a or 28a-f ehow ovent, the Medical Exarrina must be notified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 17 No If Yes, Give A Year or Dates:		Was Decedent of I If Yes, specify Cub	Hispanic Origin? (Spi an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)		Black, White		
215-0	within 72 ho ene. than "netur he Medical I	Completed	15. Decedent's Edu (Specify only highest grad		16a. Dece (Give life.	dent's Usual Occup kind of work done DO NOT use retire	oation during most of worki d)	ing	16b. Kind	d of Business/l	ndustry	
2	illed with Hygiene. other than	Be Com	17. Father's Name (First, Middle, Last)	5+	Rom	an Catho	lic Nun	(First, Middle,			Ministry	
rylan	should be ind Mental I	ToB	John	McHenr	<u> </u>	- Address (Sansa	Anna	10- 4- 111-		Dinnee		
	1 and 2 Health au Bm 27 le		19a. Informant's Name/Relationship (T) Sr. Loretta Cornel 20a. Method of Disposition	1, MHSH 20b. Pla	1001 ace of Dispo	W. Joppa		vson, Mr	ryla		4	
Baltimore,	permit. Pages Depertment of I Important: If it eny injury or o ongs.		1 to Burial 2 □ Cremation 3 □ F 1 to Donation 5 □ Other (Specify) 21. Sign while of Fureral send calcols	New	Cathe	2. Name and Addre	netery 11/				Maryland	
THE STATE OF THE S	Physician /Medical Examiner		Martin D. Yaws 23a. Part1. Enter the disease, or compleshock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	ications that caused the death.	Do not ent	500 York er the mode of dyii	Road, Ba	Ltimore, or respiratory arr	Mar est,	yland	Approximate Interval Between Onset and Death	
	ite be executed ysicien and ne burial-transit	Ical Examiner	cause. (Disease or injury that initiated events resulting in death) Last C. Due to (or as a consequence of):									
	that the death certificate ed by the attending physi detached for use as the t	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome of pregnand 1 □ Live birth 2 □ Fetal d 4 □ Pregnant at time of dea 9 □ Unknown	leath 3	Ectopic pregnanc	у		230	d. Date of delik	very Day Year	
	sign sign d be	by	Part II. Other significant conditions co.	ntributing to death but not result	ting in the u	nderlying cause giv	ven in Part I.	23e. Did to	_	_	the cause of death?	
Ϋ́	ate h page	Completed						24a. Was a autops perfori	med? 2.2 No	24b. Were aut prior to co death? 1 \(\text{Yes}	opsy findings available ompletion of cause of	
_	ng Pro	atlon; To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation		R/Outpatien 28b. Time of Injury	28c. Injui Woi	26. Place of Death ner: 4 \int Nursing Hor y at k? Yes 2 \sum No		ence 6	Other (Specioccurred	(fy)	
DIVIS	To the hospitet or Attendiving the formal within 24 hours after death. To the Funeral Director: A completely filled in by the funeral formal	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury - At hom building, etc. (Specify)	ne, farm, str	eet, factory, office		28f. Location (St City or Town	treet and f n, State)	Number or Rur	al Route Number,	
:	te frospi 24 hou te Funer letely fill	edical	29a. Certifier 1 Certifying Phy (Check only one)	sician: To the best of my knowled ner: On the basis of examination and manner stated.	iedge, death on and/or inv	n occurred at the till vestigation, in my o	me, date and place, a ppinion, death occurre	and due to the ca ad at the time, d	ause(s) an ate and pl	nd manner as a lace, and due	stated. to the cause(s)	
,	withir To th	Me	29b. Signature and title of certifier M. C 9	Kony mo		29c. Licens	e number	2		signed (Month)	**	
r)		30. Name and address of person who co	ompleted cause of death (Item 2	23a) (Type,					, &	1	
	Sta Regista		Mien D. Kioune, M 31. Date filed (Month, Day, Year)	32. Registrar's Signatu		loo. v	7					

State of Maryland / Department of Health and Mental Hygiene, 36526 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** Osaro Nwabudike Mustapha July 12. 2004 4:06 pm /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Holy Cross Hospital Silver Spring Montgomery If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months 1,□ M 2□ F None 57 July Director 2004 Maryland Usual Residence of Decedent the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Maryland | Prince Georges Beltsville 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? with ᅙ 1347 Broken Bow Court

11. Marital Status

12. Was Decedent Ever in U.S. Armed Forces?
1 | Yes 2 | No If Yes, Give Year or Dates: United States death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 🏋 No Specity: SpecifyBlack þ Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) None None filed 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) of Health and Mental Hitem 27 is marked otter rother traumatic even Be Pages 1 and 2 should be Azeez Mustapha Yusuf Ann Nwabudike 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Ann Nwabudike 11347 Broken Bow Ct. Beltsville, MD 20705 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1 Department of H important: If ite any injury or ot once. 1X Burial 2 Cremation 3 Removal from State Gate OF Heaven July 19, 2004 Silver Spring, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Simple Tribute 1040 Rockville Pike 21. Signature of Fureral Service Licensee Rockville, MD 20852 ens 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition **Physician** Extreme Prematurity resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Preterm Labor Examiner Hospital or Attending Physician: The law requires that the death certificate be executed Preterm Prolonged Rupture of Memorane attending physicien and Due to (or as a consequence of: Box 68760 by Physician/Medical as the IF FEMALE: use 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Year þ Month 4 Pregnant at time of death 5 Other (specify) ☐Yes 2☐No o 9☐ Unknown 9 Unknown Division of Vital Records, P. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ed bluods 1 ☐ Yes 2 💹 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed 1 ☐ Yes 2 ☐ No 1 Yes 2X No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: X Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2X No P 2 ER/Outpatient 3 DOA 28b. Time of Injury 27. Manner of Death 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: A ter 5 Pending investigation 1 ☐ Yes 2 ☐ No М death. 2 Accident within 24 hours after death To the Funeral Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Chack only onel and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and life of certifier up. Doo5882 July 12, 2004 30. Name and address of person who complete cause of death (Item 23a) (Type, Print) Upsana Bhatnagar 9801 Georgia Avenue Suite 224 Silver Spring, MD 20902 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

			1 - For State Registrar 1. Decedent's Name (First, Middle, Last)	State of Maryland	/ Depa		lealth and I	Mental Hy	giene Reg. No.	2004	36527
	Physici /Medic Examin	al	Osariemen Nwabudik 4a. Fecility Name (If not institution, give s Holy Cross Hospita	street and number)		Silver S	or Location of Death Spring	July 12,	4c. Mo1	04 County of Death ntgomery	7
	Funeral Director		5. Social Security Number 6. Sex None 1 Usual Residence of Decedent 10a. State 10b. County	IM 2√2 F	Yrs. Town or Lo	If Under 1 Year Months Days cation	If Under 24 Hrs. Hours Min. 1 1	8. Date of Birt (Month, Da) July 12	h y, Year) • 20	9. Birth Col 04 Mary	plece (State or Foreign untry) Land 10d. Inside City Limits
	with the Mary a or 28s-f sho be coulfied	Director	10e. Street and Number 1347 Broken Bow Co		ville	10f. Zip Code				izen of What Co	
920	be filed within 72 hours after death with the Maryland tial Hygiene. do other than "naturel", or items 23a or 28s-f show event, it a Medical Exaction must be redified at	۵	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2& No If Yes, Give Year or Dates:		20705 Was Decedent of H f Yes, specify Cub	Hispanic Origin? (Span, Mexican, Puerto			ed State 14. Race - Amer Black, White Specify Blace	ican Indian, , etc.
21215-0	ed within 72 ho giene. er then "natur , tre Medicel i	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12) None	cation e completed) College (1-4or 5+)	(Give	lent's Usual Occup kind of work done DO NOT use retire	during most of work	king	16b. Ki	nd of Business/I	ndustry
aryland	should be filed and Mental Hygi s marked other umatic event, I	To Be (17. Father's Name (First, Middle, Last) Azeez Mustapha Yusi 19a. Informant's Name/Relationship (Ty,		19b. Mailir	ig Address (Street	Ann Nwab	udike			ip Code)
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other treumatic as <u>once.</u>		Ann Nwabudike/Mothe 20a. Method of Disposition 1 Burial 2 Cremation 3 GR 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Ucense	emoval from State Gate	of He	atory or other pla Eaven . Name and Addre	July	19, 200	4 Si	2070 cation - City or 1 Llver Sp 2 1040 R	
760,	Physician /Medical Examiner and pnique residual fransit	dical Examiner	23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that intitated events resulting in death) Last	Due to (or as a consequent of the to (or as a consequent of the to consequent of the to (or as a	turit nce of): nce of):	.y			rest,		Approximate Interval Between Onset and Death
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ص	w requires that the der been signed by the a should be detached f	by	Part II. Other significant conditions cor	ntributing to death but not resulti	ing in the ur	nderlying cause giv	en in Part I.		es 2 g		the cause of death?
Vital Records	The law ate has b page 2 s	e Completed	25. Was case referred to medical				26. Place of Dea		sy med? 20 No	24b. Were aut prior to death? 1 \(\sum \text{Yes} \)	opsy findings available ompletion of cause of
ot	To the Hospital or Attending Physicien: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	ToB	examiner?	lospital: X Inpatient 2 EF 28a. Date of Injury (Month, Day Year)	NOutpatien 8b. Time of Injury	28c. Injur Wor	er: 4 Nursing H	ome 5 Resid	lence 6		ify)
Division	oital or Atteurs after desertal Directo	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At hom building, etc. (Specify)				City or Tow	m, State,)	al Route Number,
	To the Hospital within 24 hours a To the Funeral I completely filled	Medicai	(Check only 2 Medical Examile one)	sician: To the best of my knowle ner: On the basis of examination and manner stated.		estigation, in my o	pinion, death occur	red at the time, o	date and	place, and due	to the cause(s)
)	Mili To Cor	~	29b. Signature and title of central and address of person who co	nigleted cause of death (Item 2	3a) (Type	29c. Licens D00588	82	J	uly	12, 200	
	Sta Registi			20902 32. Redistrar's Signatur	ή		-in bilati	.ugai 70	VI is	eurgia .	avenue#224

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 29, 7:24 PMM Robert McMullan October | 2004 /Medical 4b. City. Town, or Location of Death 4c. County of Death 4a. Fecility Name (If not institution, give street and number) Examiner Prince George's Medical Center Prince George's Cheverly 8. Date of Birth (Month, Day, Yee Apr 16, 1 If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country)
 UNK 7. Age (In yrs. last birthday) 5. Social Security Number unk 6. Sex **Funeral** Days Hours 72 1932 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County or 28a-f ahow traumatic event, the Medical Examiner must be notified at MD 1 Yes 2 No Prince George's Riverdale Director 10g. Citizen of What Country? 10f Zin Code 10e. Street and Number 6370 67th Court 20737 **USA** Items 23a Funeral death Was Decedent of Hispanic Origin? (Specify Yes or Notif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race · American Indian. 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If tem 27 is marked other than "natural", or them any injury or other traumatic event, the Martins of Once. 1 Yes 2 No
If Yes, Give
Year or Dates: 1 Never Married 2 Married unk Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No þ white 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry unk unk Elementary/Secondary (0-12) College (1-4or 5+) unk unk 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) unk Be unk 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Prince George's Medical Center 20b. Place of Disposition (Name of cametery, crematory or other place)

Cheverly MD 24785

Date 20c. Location : City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State * 4 ☐ Donation 5 ☑ Other (Specify) in state 21. Signature of Funeral Service Licensee Ronald S. Wa 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Wade, Dixted 23a. Part I. Ever the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Finat disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner rolamyo Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed use as the burial-transit and Due to (or as a consequence of) Box 68760. attending physician Physiclan/Medical IF FEMALE: 23c. tf yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year Day jo in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) P.O. page 2 should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed? certificate 1 Yes 2 No neumonio To the Hospital or Atlanding Physician: 26. Place of Death (Check only one) funeral director, 25. Was case referred to medical Be Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 ☐ No 2 ER/Outpatient 3 DOA Pis 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of tnjury 27. Manner of Death After 1 Natural 5 Pending s after death.
I Diractor: Aft 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a pellij t Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only onel and manner stated 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certified 29c. License number 3/04 006033 30 Name and address of person who completed cause of death (Item 234) (Type, Print) e Ka 31. Date filed (Month, Day, Year) 32. Registrar's Signature, State oaks Registrar NOV 1 8

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) NOVEMBER 15, 2004 **Physician** 1900 MOLOTCH SHIRLEE DELORES /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** N/A LEVINDALE HEBREW HOME BALTIMORE If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. 0 CMonth Day, 1919 Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 5. Social Security Number **Funeral** 1 □ M 2 🔽 F V٨ 85 218-10-1411 Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County or 28e-f show event, the Medical Exposiner must be notified at 1 TYYes 2 □ No Funeral Director BALTIMORE N/A 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 2434 W. BELVEDERE AVENUE 21215 USA or Items 23e deeth 1 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: if itam 27 is marked othar then "natural", or Ite mortant if itam 27 is marked othar then "natural", or Ite and injury or othar traumatic event, the Medical Extrainment and. 1 ☐ Yes 2 💢 No If Yes, Give Year or Dates: 1 Never Married 2 Married WHITE Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: þΛ 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) OWN HOME HOMEMAKER 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be SHAPIRO BERGER MOLLIE MAURICE 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1000 FALLSCROFT WAY - LUTHERVILLE, MD 21093 STEPHEN L. MILES / SON 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a, Method of Disposition Burial 2 ☐ Cremation 3 ☐ Removal from State WOODLAWN, MD BETH TFILOH CEMETERY 11/17/2004 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 1 ola 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition resulting in death) END-STAGE DEMENTIA **Physician** /Medical Due to (or as a consequence of). **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The taw requires that the death certificate be executed anding physician and use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 the attending physician Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) detached o∏ Unknown s been signed by the should be detached Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 ☐ Probably 4 XUnknown FAILURE TO THRIVE 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy 1 Yes 2 X No To the Hospitel or Attanding Physician: 25. Was case referred to medical examiner? the funeral director. 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 X Nursing Home 5 Residence 6 Other (Specify) Medical Certification; To 1 ☐ Yes 2 X No 28a. Date of Injury (Month, Day Year) 27. Manner of Death Injury at Work? 28d. Describe how injury occurred 1 X Natural 2 Accident Iniurv 5 Pending 1 Yes 2 No investigation 6 Could not be determined 3 Suicide within 24 hours after der To the Funaral Diracto completely filled in by th 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier 29d. Date signed (Month, Day, Year) 29c. License number D50757 11/16/2004 ď 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2434 W. BELVEDERE AVENUE - BALTIMORE, MD 21215] 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 1 8 2004 Registrar

			1 For State	State of Maryl	and / Dep	artment of I	Health and M	/lental Hyg	iene	
			Registrar 1. Decedent's Name (First, Middle, L	a cr)	Ce	rtificate of	Death	2. Date of Deat	9. Ng? 00L	36530
	Physici		Mary Merza	a31)				Month	Day Year 10, 200	10:48A.M
	/Medio Examir		4a. Facility Name (If not institution, g	ive street and number)		4b. City, Town, o	or Location of Death		4c. County of D	
П			Laurel Regional	Hospital		Laure	l			e George
	Funeral Director		083-68-5091	Sex 7. Age (In) 1 □ M 2√2 F 8(rs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Nov. 15,	Year) 9. E 1923 L	Birthplace (State or Foreign Country) ebanon
	ow ou		Usual Residence of Decedent 10a. State 10b. County	10c.	City, Town or Lo	ocation				10d. Inside City Limits
	a-f sh	ctor	MD Anne A	Arundel	Laurel					1 ☐ Yes 2√ No
	or 28	Oire	10e. Street and Number			10f. Zip Code			g. Citizen of What	Country?
	ath w	rail	8013 Big Pool Ro	T		20724			Lebanon	
39	be filed within 72 hours after death with the Maryland stal Hygiene. od other than "natural", or Hems 23e or 28e-1 show event, the Medical Examinar must be follified at	by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ② Widowed 4 ☐ Divorced	12. Was Decedent Ever i Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:		Was Decedent of I If Yes, specify Cub 1 ☐ Yes 🏋 No	Hispanic Origin? (Span, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	Black, W	mencan Indian, hite, etc. White
Maryland 21215-0036	in 72 hou n "nature Vedical E	Completed	15. Decedent's (Specify only highest g	rade completed)	16a. Dece (Give life.	dent's Usual Occup kind of work done DO NOT use retire	pation during most of work d)	ring	16b. Kind of Busine	ss/Industry
212	od within giene. er than "	Com	12	College (1-4or 5+)	Но	memaker			Own Home	
nd	be filed tal Hygi d other event, I	Be	17. Father's Name (First, Middle, Las	17)				e (First, Middle, N		
yla	should be nd Mental marked o matic eve	ဥ	Youssef Karam	The Date	1			(Unavai		
Mai	d 2 st th and treun treun		19a. Informant's Name/Relationship Naim Merza / Sor						City or Town, State	
ē,	permit. Pages 1 and 2 should b Department of Health and Ments Important: If item 27 Is marked any injury or other treumatic e once.		20a. Method of Disposition	20	b. Place of Dispo	sition (Name of			Oc. Location - City	
Baltimore,	Page Nent o nt: If Iry or		1 ☑ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spec			Cemetery of other pla	,	2/2004	Laurel	Maryland
<u>a</u>	permit. Departm Importa any inju		21. Signature of Edneral Service Lice						ral Home,	Inc.
<u> </u>	8958		- senja s	2000mg		7601 Sand	ly Spring	Road, La	urel, Ma	ryland 20707
			23a. Part1. Enter the disease, or co- shock, or heart fallure. List onl	nplications that caused the d y one cause on each line.	leath. Do not en	ter the mode of dyir	ng, such as cardiac	or respiratory arre	st,	Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a Coronary		Disease				1Yr.
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	ocuted nd transii	Examiner	that initiated events	C						
,160,	ate be executed hysician and the burial-transit		resulting in death) Last	Due to (or as a cons	sequence of):					
6876	physic physic the b	dlcal	•	d						
Вох	certif nding use as	n/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pre			•		23d. Date of d	lelivery
	that the death hed by the atter detached for i	Physician/Med	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 ☐ Live birth 2 ☐ F 4 ☐ Pregnant at time of 9 ☐ Unknown		Ectopic pregnancy Other (specify)	/		Month	Day Year
S, D	requires that the reen signed by th hould be detache	by P	Part II. Other significant conditions	contributing to death but not	resulting in the u	nderlying cause giv	en in Part I.	23e. Did toba	acco use contribute	to the cause of death?
ord	w require been signal		Status P	ost Cerebrova	scular A	Accident		1 ☐ Ye	s 2 No 3	Probably 4 XUnknown
ပ္မ	aw 1s b	Completed						24a. Was an autopsy	prior to	autopsy findings available o completion of cause of
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Vital	Physician: this certific ral director,	Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:	Flence	3 DOA Oth	ar.	h (Check only one		
ō	ding Physician: The Ih. After this certificate ha funeral director, page	n: To	1 X Yes 2 □ No 27. Manner of Death	1 Inpatient 2 28a. Date of Injury (Month, Day Year	28b. Time of	IL SEL DON	+□ Nursing ⊓o	me 5 Resider 28d. Describe how	nce 6 Other (Sp winjury occurred	pecify)
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	Within To the complete	Me	29b. Signature and title of certifier	- PD		29c. Licens	e number	29	d. Date signed (Moi	nth, Day, Year)
				- \$40 C	2 M	D247	21		Novemb	er 11, 2004
	n)		30. Name and address of person who				200 7	1 201 000		1, 1,
	Sta	te.	Syed Sadiq , 1	M.D. 14333 Lat A 32 Registrar's Si	dret ROM	Te Kd. #	zuo Laure	1, Md 20	/08	
	Registr		31. Date 100 Vorh, 8 2004	pener	p Ay	oaks				

			For State Registrar AMEND TTEM 1. Decedent's Name (First, Middle, Las	State of Ma #26 PER ME						leg. No.	2004	3653
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	ledic amin		4a. Facility Name (If not institution, give		-		4b. City, Town, o	r Location of Deat			County of Death	13.37
			600 46th Street				Dunda	alk			Baltim	ore
Fune	eral		Social Security Number 6. Se		(In yrs. last I		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	(Month. Day	Year	Coun	ace (State or Foreig
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and w		-	Usual Residence of Decedent 10a. State 10b. County		10c. City, To	wn or Lo	ation				10	Od. Inside City Limit
Maryl f sho	E 0 3	5	Maryland Baltimo	ro	D.,	ndal	l _z					1 □ Yes 2 ᡚ N
the 28a	Digital Control	Director	10e. Street and Number		Du	iiuai	10f. Zip Code	<u> </u>		IOa. Citiz	zen of What Coun	
with 3a or	92		600 46 th Street							3		
death ms 2		Funerai	11. Marital Status	12. Was Decedent E	ver in U.S.	13. V	21224 Vas Decedent of H	lispanic Origin? (S an, Mexican, Puert	pecify Yes or No-	1	U.S.A 14. Race - America	an Indian,
after or Ita	a dice	Ē	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☑ No	0				o Rican, etc.)		Black, White, e	etc.
ours	EXE	d by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		_	☐ Yes 2X No	Specify:			Specify: Whi	te
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7 1	rtra		John A. Grynkiewic	z (Uncle				Ave. Bal		-		,
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permit. Pages Department of Important: If it	ry or		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Removal from State)				Inc. 18,	K	Ralt.	imore, Ma	aruland
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The law requires that the death certificate be executed the has been signed by the attending physician and considered to the considered to		edicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a c. Due to (or as a d.								
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ysic lis ce	ō	To B	examiner? TXXYes 2 □ No	Hospital: 1 Inpatient	2 🗆 ER/0	utpatient	3□ DOA Othe	er: 4 Nursing Ho	ome 5 Reside	nce (X	(XOther (Specify)	SCENE
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death.	the fu	cati	2 Accident investigation 3 Suicide 6 Could not be				M 1 []	Yes 2 □ No				
	led in by	Certification:	4 Homicide determined	28e. Place of Injury building, etc.	y - At home, (Specify)	farm, stre	et, factory, office		28f. Location (St City or Town		Number or Rural	Route Number,
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To the within 2 To the	com	Σ	29b. Signature and title of certifier	0 0	0		29c. License	number	2	d. Date	signed (Month, D	ay, Year)
			1 Tapisul	al Al	٦`			O.C.M.	E.	Nove	mber 15,	2004
4			30. Name and address of person who of	ompleted cause of dea				et, Balt	imore, M	aryl	and 2120	1
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State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year **Physician** NORMAN S. NOGIC 2/30 PM OVEMBER 15 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City Town or Location of Death 4c. County of Death Examiner UPPER CHESAPEAKE MEDICAL CENTER AIR HARFORD If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Funeral X1X□M 2□F Months 180-09-7552 86 Director 08-22-1918 PENNSYLVANIA Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits itam 27 Is marked other than "natural", or Itams 23a or 28a-f show other traumatic event, the Medical Examinar must be notified at MD. BALTIMORE KINGSVILLE 1 Yes 2XXNo Director the 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 11932 BELAIR ROAD 21087 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married XX Married 1 ☐ Yes XX No Specify: ģ WHITE If Yes, Give Year or Dates: Specify: 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) 12 should be filed within 72 h and Mental Hygiene." 7 Is marked othar than "na Elementary/Secondary (0-12) College (1-4or 5+) AERO. SPACE MECHANICAL ENGINEER YEARS INDUSTRIES 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) LEON NOGIC ANTONIA MADAJEWSKI 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If itam 27 Is rr any njury or othar traum 900.9. BETTY Α. NOGIC (WIFE) 11932 BELAIR ROAD, KINGSVILLE, MARYLAND, 21087 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2√CyCremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) HILLTOP SERVICE CORP 11-18-2004 TOWSON, MARYLAND, 21204 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 1050 YORK ROAD RUCK TOWSON FUNERAL HOME, INC. TOWSON, MD.21204 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician 2004 disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner same Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): the attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year 4☐Pregnant at time of death Day 5 Other (specify) 1 ☐ Yes 2 ☐ No 9☐ Unknown 9 Unknown à Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? page 2 should be 1 ☐ Yes 2 ☐ No 3 Probably 4 □Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has t autopsy performed? Yes 21 No certificate 1 ☐ Yes 2 ☐ No Yes the Hospitel or Attanding Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 XNo 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 XNatural 2 Accident 5 Pending death. 1 ☐ Yes 2 ☐ No investigation within 24 hours after death To the Funerel Director: 3 🗌 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D-0018779 November 16, 2004 U. En Tun 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Harford Road, Suite 105, Fallston 2 71 M.D. 31. Date filed (Month, Day, 8 2004 32. Registrar's Signature Registrar

Vorman

#3/6/68

State of Maryland / Department of Health and Mental Hygier 00 4 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death November 10, **Physician** Brown 0'Neal 2004 Tde11 2:05 PMM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1608 Debra Drive Waldorf Charles 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth Month, Day, You July 26, **Funeral** 9. Birthplace (State or Foreign Year 1914 Laure Thill, LA 1 ☐ M 2 🖾 F 90 Months Days Hours Min 434-20-6604 Yrs. Director Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Itam 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Madical Examination must be notified at Orleans New Orleans Director T.A 1X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1209 Lamanche Street 70117 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, permit. Pages 1 and 2 should be filed within 72 hours atter c Department of Health and Mental Hygiene. Important: if Itam 27 is marked other than "natural", or iten any injury or other traumatic event, the Medical Examplest ODE. Black White etc 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Completed by Specify: Black 3 X Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Teacher Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Willie Brown Maria Butler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Anita O'Neal - Daughter 1608 Debra Drive Waldorf, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State N Burial 2 ☐ Cremation 3 ☐ Removal from State Mt. Olivet 11/18/04 4 ☐ Donation 5 ☐ Other (Specify) New Orleans, LA 22. Name and Address of Facility Louisiana Undertaking 21. Signature of Funeral Service Licensee 1449 North Clairborne Ave New Orleans, LA Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or head failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause Final disease or condition resulting in death) **Physician** Alzheimer's Disease Years /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, it any, leading to him leading to him leading cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine The law requires that the death certificate be executed the attending physician and hed for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 4☐Pregnant at time of death Month Day Year 5 Other (specify) Division of Vital Records, P.O. 9 Unknown 9 ☐ Unknown ģ signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Atherosclerosis 1 Yes 2 No 3 Probably 4 □Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate 1 Yes 2 No 1 ☐ Yes 2 X No Hoapital or Attending Phyalclen: 25. Was case referred to medical examiner? Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 X No ို 1 Inpatient 2 EP/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) After thi 27. Manner of Death 1 △Natural 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred s effer decreal Director: After 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be determined 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide To use within 24 hours ence To the Funeral Dir 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical onel 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D19431 11-11-04 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 11701 Livingston Road Ft. Washington, MD Frank Ryan, MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar NOV 1 8 2004

e	State of Maryla	nd / Department of Health and N		0.000
1 - For State Registrar		Certificate of Death	Reg. No.	36534
Physician /Medical	First, Middle, Lest) PA3/ei	Toub and earlies of Death	2. Date of Death Month Day November 16, 6	Year 9,05AM
Examiner 4a Fability Name (f ngt institution, give street and number)	BAIT MORE	4c. Count	9/7
Funeral 5 ocial Seguity N	50/4 10M 20 F W4	s. last birthday) If Under 1 Year If Under 24 Hrs. Yrs. Months Days Hours Min.	8. Date of Birth	9. Birthplace (State or Foleign
	10b. County A 10cg	Sity Tolkinjor Location OA 1 + 1 MORE		10d. Inside City Limits 1 ☑ Yes 2 ☐ No
Internal Picture of the Mar rith of the Mar ri	K. BULLIE St.	101.70 Code (1)	10g. Citizen of	What Country?
215-0036 215-0036 thin 72 hours after death with the Maryla after death with the Maryla and Table 10 to 10	12. Was Decedent Ever in Armed Forces? 1 Yes 2 No 1 Yes, Give Year or Dates:	U.S. 13. Was Decedent of Hispanic Origin? (Sr If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 ☑ No Specify:	pecify Yes or No- Brican, etc.) 14. Rad Bla Specif	e - American Indian, ck, White, atc. v: BAUK
~ \$ 8 S S S S S (1+	15. Decedent's Education ity only highest grade completed) hdary (0-12) College 1-4or 5+)	16a. Decedent's Usual Occupation (Give kind of work done during most of work (Fig. DONOT use retired)	king 16b, Kind of B	usiness/Industry HUBE
	First Middle, Last) JUNNSON	1a Mamer's Nam	e (First, Middle, Mallen Syrifa	PEWS
	ame/fieldtionship (Type/Page)	19b. Mailing Address (Street and Nymper or Ru	ral Route Nymber, City or Town	State Ziol Code y (2)
O Solling 1 Burial 2	position Cremation 3 □ Removal from State 5 □ Other (Specify)	Place of Disposition (Name of Igental pay, cramatory, or other place)	Date 200 Location	City or Town, State
A Donation A Donation The page of the pa	thin F. SAME	22. Name and Address of Facility JC	SEPH D. 000	NG. 21202
Immediate Cause	(Final	ath. Do not enter the mode of dying, such as cardiac	or respiratory arrest,	Approximate Interval Between Onset and Death
Physician disease or condition resulting in death) Examiner		aquence of):		
Sequentially list or if any, leading to in cause. Enter Und. Cause Clisuase that initiated event resulting in death)	onditions, neediate b. Due to (or as a consecution)	equence of):		
760 te be se bur	c	aquence of):		
Division of Vital Records, P.O. Box 68 To the Hospital or Attending Physician: The law requires that the death certifical within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physologiety filled in by the funeral director, page 2 should be detached for use as the completely filled in by the funeral director, page 2 should be detached for use as the completed by the attending physician Certification: To Be Completed by Physician/Medical Certification: To Be Completed by Physician Medical Certification: To Be Completed by Physician Medical Certification: To Be Completed by Physician Medical Completed by Physician Medi	menths? 4 Pregnant at time of	ital death 3 ☐ Ectopic pregnancy		te of delivery nnth Day Year
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Of Vital Records, Physician: The law requires t ruhis certificate has been signe ral director, page 2 should be completed by S. S. Manual of Dea S. Wanual of			autopsy performed?	Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No
25. Was case refe examiner?	Hospital		th (Check only one)	
To sit in a	th 28a. Date of Injury 5 Pending (Month, Day Year)	28b. Time of 28c. Injury at Work?	ome 5 Residence 6 Oth 28d. Describe how injury occur	red
DIVISION B or Attending P 1 Director: After I 2. Watural 5 Variance A Pumping P 1 Matrial 6 Matrial 7 Homicide 7 Homicide	investigation 6 Could not be determined 28e. Place of Injury - At building, etc. (Special Countries)	M 1 ☐ Yes 2 ☐ No home, farm, street, factory, office cify)	28f. Location (Street and Numb City or Town, State)	per or Rural Route Number,
he Hospita no 24 hours no 24 hours no 24 hours (Check only one)	Certifying Physician: To the best of my k 2 Medical Examiner: On the basis of examinand manner stated.	nowledge, death occurred at the time, date and place, nation and/or investigation, in my opinion, death occur	and due to the cause(s) and ma red at the time, date and place,	anner as stated. and due to the cause(s)
ett o o o o o o o o o o o o o o o o o o		29c. License number	29d. Date signe	d (Month, Day, Year)
	Du Ihuy mo	D40854	11/1	6/2004
30. Name and add	ress of person who completed cause of death (It	em 23a) (Type, Print) ST PGUL PI BOLLIN	nore moli s	21202
State 31. Date filed (Mod Registrar	nth, Day, Year) 32. Registrar's Sig	parks sparks		

			For State Registrar		State	of Mar	ryland		artment of rtificate o			ental Hy	giene	2001	0.4	
			Decedent's Name (Fig. 1)	irst, Middle,	Last)							2. Date of De	aath	CUU4	3. Time a	bealin 5
H	Physicia /Medic		Martin Fra	ncis	Rouse, S	r.						Month 11	Day 15	Year 2004	1:00	Ам
	Examin		4a. Facility Name (If no						4b. City, Town	, or Location	of Death	- AA		County of Death		
		-	Mariner H	ealth	of Cato	nsvil	lle		Catons				В	altimore	<u>.</u>	
	Funeral		5. Social Security Numb		5. Sex 11 <u>√2</u> M 2 ☐ F	7. Age ((In yrs. las	st birthday) Yrs.	If Under 1 Yes Months Day		Min.	8. Date of Bir (Month, Da	th ay, Year)	9. Birth Cou	place (State ontry)	or Foreign
	Director	}	216-20-365 Usual Residence of De			77		115.				9-7-19	27	Penr	ısylvar	nia
	ow ow			b. County		1	10c. City,	Town or Lo	cation						10d. Inside C	ity Limits
	Mary 1-1 sh	tor	MD :	Baltin	nore		Cato	nsvil	1e						1 🗆 Yes	2 ₽ No
	th the	Director	10e. Street and Number	er					10f. Zip Code	€			10g. Citi	zen of What Cou	ntry?	
	23a c		1137 Ingl	eside	Ave				212	07			U.	S.A.		
	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or items 23a or 28a-f show int, the Madical Examinat must be natified at	Funerai	11. Marital Status		12. Was De Armed F	cedent Ev	er in U.S.		Was Decedent of Yes, specify C	f Hispanic Or uban, Mexica	rigin? (Spe n, Puerto f	cify Yes or No Rican, etc.))-	14. Race - Ameri Black, White,		
36	s afte	by Fi	1 Never Married 3 Widowed 4		If Yes, G	2 □ No live 11	-1 84	5	1 ☐ Yes 2 ☐ N	lo Specify	:			Specify: Whi	te	
8	hour tural			. Decedent's	Year or Education	Dates:12			dent's Usual Occ	unation				nd of Business/Ir		
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212	d with giene or tha	mo:	Elementary/Seconda 12	iry (0-12)	College	(1-4or 5+)		Sales	man				Auto	omobile		
b	al Hyll othe	Вес	17. Father's Name (Firs	st, Middle, L	ast)					18. Moth	er's Name	(First, Middle	, Maiden	Ѕитате)		
yla	Ment Ment arkec	To I	Leo Thomas	Rouse					_			s McDo				
lar	iges 1 and 2 should be filed within 72 hours after death with the Marylan nt of Health and Mental Hygiene. If item 27 is marked other than "naturat", or items 23a or 28a-1 show or other treumatic event, It is Madical Examinating and itself a		19a. Informant's Name						_					r Town, State, Zij		
6	os 1 and 2 of Health a item 27 le other treu		Martin F.]		Jr./Son	n.	1		Tall Pin sition (Name of	nes Ct		onsvil		MD 21228		
Baltimore, Maryland 21215-0036	permit. Pages 1 an Department of Heal Importent: If item 2 eny injury or other once.		1 ☐ Burial 2 ☐ C	remation		n State	cen	netery, crei	natory or other p dral Cei	netery				cation - City or T timore,		
豊	it. Partmer	1	4 ☐Donation 5 ☐ 21. Signature of Funera	17			1		. Name and Add			10 04	рат	cimore,	riD	
Ba	permi Depar Impo eny ir		100	N I	200	NOO		A	mbrose 1	Funera	1 Hom	e, Inc	• .	1m 0	1007	
			23a. Part1. Enter the d	disease, or c	omplications that	caused th	ne teath.	Do not ent	er the mode of d	ying, such as	cardiac o	r respiratory a	rbuti rrest,	us, MD 2	Approximat	te
	Physician		shock, or heart fa Immediate Cause (Fina		-			O to A	- a.c.	4C)_					Onset and	ween Death
	/Medical		disease or condition resulting in death)		aDue to	o (or as a	Conseque	nce of):	Z DISEN	DE						
	Examiner		Constitution to a solital		b. D11	ABLIT	10/	VAPITA	POPATIF	Y						
./.	(D =	iner	Sequentially list conditi if any, leading to imme- cause. Enter Underlyin	diate		o (or as a										
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8760,	cate be executed physician and the burial-transit	ai E			Due to	o (or as a	conseque	nce or):								
387		dicai		- 3	d											
9 x	that the death certif ed by the attending detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pre	egnant	23c. If yes, o								2	23d. Date of deliv	erv	
Вох	death a atter	iciar	in the past 12 mor	nths?	4□Preg	birth 2 nant at tir			Ectopic pregnar Other (specify)	тсу				Month	,	Year
o.	t the c by the achee	hysi	9 Unknown		9□Unk	nown										
S, P	res tha igned be del	by P	Part II. Dther significan	nt condition	s contributing to	death but	not resulti	ng in the u	nderlying cause	given in Part	l.	23e. Did t	obacco us	se contribute to t	he cause of c	death?
ord	w require been si should b											1 🗆	Yes 2	□No 3□Prot	oably 4 📶	Jnknown
Vital Records,	e faw r has be je 2 sh	Completed										24a. Was	OSV	24b. Were auto	psy findings mpletion of c	available ause of
E E		Con										perfo	2 No	death?	Z No	
/ita	icien: Th certificate rector, pag	Be	25. Was case referred examiner?	to medical	II						e of Death	(Check only o	one)			
		70	1 ☐ Yes 2 ☑ No		-	Inpatient		VOutpatier	t 3 DOA					Other (Specif	(y)	
UC	Jing After fune	tion		Pending	(Mo	of Injury nth, Day Y	Year)	8b. Time of Injury	W	jury at /ork? □ Yes 2 □		8d. Describe	now injury	occurred /		
Division of	Attending ir death. ector: After by the fune	ficat		investiga	t be 290 Plac	e of Injury	v - At hom	e. farm. str	eet, factory, office			8f. Location (Street and	d Number or Rura	al Route Num	ber.
Ω	after after Dire	Certification;	4 Homicide	determin		ding, etc.		.,,	,,			City or To				
	To the Hospitel or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral		29a. Certifier 1	Certifying	Physician: To th	ne best of	my knowle	edge, deatl	occurred at the	time, date ar	nd place, a	nd due to the	cause(s)	and manner as s	tated.	
	n 24 i	Medical	(Check only 2] Medical E	xaminer: On the and ma	basis of e nner state	xamination ed.	n and/or in	estigation, in m	y opinion, dea	ath occurre	d at the time,	date and	place, and due to	o the cause(s	i)
	To the composition	Σ	29b. Signature and title	of certifier					29c. Lice	nse number				e signed (Month,		
			MULLIAN	Kun					445				N	NEMBE	216,	200
	12		30. Name and address	of person w	72.20 32. 8 2004	use of dea	th (Item 2	3a) (Type,	Print)	CA- W	2A 77	AL INDE	. 5	12013		
	Sta	te	UEDOTA h 31. Date filed (Month, L	Day, Year)	32.	Regi r ar'	s Signatur	0 0000	11000	ال ال	110 10	TULE		12.00		
	Registr	7		NOV 1	8 2004	Med	was.	B,	gover							

	Amend item#20b, perFH, G837, 11/23/04 II State of Maryland / Dep 1- Registrar AMEND TTEM #10b PER TNE C838		
Physician /Medical	1 - State Registrar AMEND TTEM #10b PER INF G838 1. Decedent's Name (First, Middle, Last) LUSSELL ROPER ROWE	12/01/04 5Harr 2. Date o Month No. 10	f Death Day Year 3. Time of Death
Funeral Director	4a. Facility Name (If not institution, give street and number) Union Memoria 5. Social Security Number 6. Sex / 7. Age (In yrs. last birthda / Yrs. 1 Yrs. Y	y) If Under 1 Year If Under 24 Hrs. 8. Date o (Month)	Birth Say, Year O 9. Birthplace (State or Foreign Country)
or 28a-1 show e notified at	Usual Residence of Decedent 10a. State 10b. County HOWARD 10c. City, Town or 10e. Street and Number	Noodstock 10f. Zip Code	10d. Inside City Limiys 1 ☐ Yes 2 12 No 10g. Citizen of What Country?
5-0036 72 hours after death with the Maryla natural; or Itams 23a or 28a-1 shoulded Examiner must be notified at eted by Funeral Director	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:	3. Was Decedent of Hispanic Origin? (Specify Yes o If Yes, specify Curan, Mexican, Puerto Rican, etc.	r No- 14. Race - American Indian, Black, White, etc. Specify: BIACK
_ c * # =	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last)	pedent's Usual Occupation we kind of work done during most of working DO NOT use retired 13 Mother's Name (First, Min	Federal Government addio, Majdon Surnamo)
ire, Maryland 212's as 1 and 2 should be filed within of Health and Mental hygiene. Item 27 is marked other than other traumatic event, It. M. To Be Comp	9a. Informant's Name/Relationship (Type, Print) Shelia M. Ruwe (WiFe) 20a. Method of Disposition 20b. Place of Dis	More C illing Address (Street and Number or Rural Route No Chaucle Way Woo position (Name of Date	detack. MD 21163
Baltimore, permit. Pages 1 a Department of Her Important: If item any injury or othe	1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State	Druid Ridge 11-,22-0	Pikesville Horiottsville MD Greene Fundal Sewick Mallstown MD 2133
Physician /Medical Examiner	23a. Part 1. Enter the disease, or complications that caused the death. Do not a shock, or hean valure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence of):	enter the mode of dying, such as cardiac or respirator	Approximate Interval Between Onset and Peath
58760, ireate be executed physician and s the burial-transit edical Examiner		Cyll Cycle	G YOTO,
vision of Vital Records, P.O. Box 6876. Attanding Physician: The law requires that the death certificate be reteath. actor: After this certificate has been signed by the attending physicia by the tuneral director, page 2 should be detached for use as the buffication: To Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown	3 ☐Ectopic pregnancy 5 ☐ Other (specify)	23d. Date of delivery Month Day Year
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Division of Vital Records, To the Hospital or Attending Physician: The law requires to within 24 hours after death. To the Funeral Director: After this certificate has been signe completely filled in by the funeral director, page 2 should be Medical Certification: To Be Completed by	1 ☐ Yes ONO Hospital: Onpatient 2 ☐ ER/Outpat	of 28c. Injury at 28d. Descr	nly one) Residence 6 □Other (Specify) ibe how injury occurred
Division C To the Hospital or Attending P within 24 hours after death. To the Funeral Director: Aftert completely filled in by the tunera Medical Certification:			on (Street and Number or Rural Route Number, Town, State)
To the Hospi within 24 hou To the Funer completely fill	ESS. Orginals of arts this si	investigation, in my opinion, death occurred at the ti	me, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year)
State Registrar	30. Name of address of person the completed cause of death (Item 23a) (Type Samuer World Completed cause of death (Item 23a) (Type Samuer World Completed cause of death (Item 23a) (Type Samuer Completed cause of death (Item 23a) (Typ	by 4949 North Glutsneers	81515 pm 2000th

		-	For State Registrer	e of Maryland / [-	rtment of He tificate of De			ene 004	36537
	Physicia	an	1. Decedent's Name (First, Middle, Last) Shirley Le	e Rose				2. Dete of Death Month November	Day Year 2004	3. Time of Death 6:30am M
	/Medic Examin		Aa. Fecility Name (If not institution, give street an Mariner Healt Care	·		4b. City, Town, or Lo	ocation of Death		4c. County of Death Baltimore	
Ī	Funeral Director		5. Social Security Number 6. Sex 226-52-0716	7. Age (In yrs. last bir	thday) Yrs.	If Under 1 Year I		8. Dete of Birth (Month, Day, YApr. 16,		place (State or Foreign ntry)
	D		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town	n or Loc	ration		Ap1. 10,		10d. Inside City Limits
	Maryla -f shov lied al	tot	MD Baltimore			sville				1 ☐ Yes 2 ₹ No
	ith the	Funeral Director	10e. Street and Number			10f. Zip Code		100	g. Citizen of What Cou	ntry?
	eath w	eral	1015 Crosby Road 11. Marital Status 12. Was	Decedent Ever in U.S.	13. W	212 Vas Decedent of Hisp		cify Yes or No-	USA 14. Race - Ameri	can Indian,
920	be filed within 72 hours after death with the Maryland ital Hygiene. Id other than "natural", or Items 23e or 28e-f show event, the Medical Evanifier must be notified at		1 Never Married 2 Married 1 1	d Forces? /es 2 🖸 No s, Give or Dates:	1	Vas Decedent of Hisp Yes, specify Cuban, ☐ Yes 2 No	Mexican, Puerto Specify:	Rican, etc.)	Black, White Specify: White	
Maryland 21215-0036	ithin 72 ho ne. nan "natur Medical	Completed by		ege (1-4or 5+)	(Give I life. D	ent's Usual Occupati kind of work done dur O NOT use retired)	on ring most of worki	ng 16	8b. Kind of Business/la	
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/lan	2 should be filed withir and Mental Hygiene. Is marked other than eumatic event, the Mental and the market are seent.	To Be	James Rose				Alice	Ratliff		
Man	s 1 and 2 should f Health and Men item 27 is marks other treumatic	. 4	19a. Informant's Name/Relationship (Type, Print Mrs. Betty Jane Rose (g Address <i>(Street and</i> Crosby Roa			City or Town, State, Zi ID 21228	o Code)
	s 1 and 3 of Health item 27		20a. Method of Disposition	20b. Place of	f Dispos	sition (Name of patory or other place)			0c. Location - City or T	own, Stete
Baltimore,			1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal 1 ☐ Donation 5 ☐ Other (Specify)			ptist Čem.		2/2004 We	est Friends	ship, MD
Ball	permit. Pag Department Importent: I any injury o	la p	21. Signature of Funeral Service Licensee Buan L Ha	ight	S	ykesville,	, MD 21/8	34 (410)-		(195)
	Physician	62 1	23a. Part1. Enter the disease, or complications shock, or heart failure. List only one cause Immediate Cause (Final disease or condition	that caused the death. Do	not ente	or the mode of dying, $\mathbf{a} \cdot \mathbf{a} \cdot \mathbf{a} = \mathbf{a} \cdot \mathbf{a}$	such as cardiac o	r respiratory arres	t,	Approximate Interval Between Onset and Death
1	/Medical Examiner		resulting in death)	e to (or as cons uence	of):	14.01.	-1 - h	0 5		/ 1410
		ner	Sequentially list conditions, if any, leading to introduct cause. Enter Underlying Cause (Disease or injury	e) to (or as a consequence	of):	njeu	7410 K	1/		1907
	xecuted and al-transi	Examiner	that initiated events c	e to (or as a consequence	of).	Mselea	wells	tvs.		
8760,	cate be executed bhysician and the burial-transit	dical E	d							
.O. Box 6	ath certific	by Physician/Mec	in the past 12 months?	s, outcome of pregnancy Live birth 2 Fetal death Pregnant at time of death Unknown		Ectopic pregnancy Other (specify)			23d. Date of deliving Month	rery Day Year
Δ.	quires that the de n signed by the a aid be detached i	d by Ph	Part II. Other significant conditions contributing	to death but not resulting in	in the un	derlying cause given	in Part I.	23e. Did toba 1 ☐ Yes	cco use contribute to	
I Records,		Completed				· · · · · ·		24a. Was an autopsy perform	prior to co	opsy findings available ompletion of cause of
Vital	Physicien: The this certificate ral director, pag	o Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital:	1 ☐ Inpatient 2 ☐ ER/Ou		Other	111111111111111111111111111111111111111	(Check only one)	S DOther (See	4.1
of	og Phys ter this neral di	\vdash	27. Mann of Death 28a.	Date of Injury 28b.	Time of Injury	28c. Injury a Work?	ıt i	28d. Describe how	ce 6 Other (Speci injury occurred	iy)
Division	Attending of death.	icatlo	2 Accident investigation 3 Suicide 6 Could not be	Place of Injury - At home, fa			s 2 □No	28f Location (Stre	et and Number or Rui	al Route Number
D	el or A s after el Direction	Certification:		building, etc. (Specify)	uitii, Stie	oet, ractory, omco		City or Town,	State)	
	To the Hospitel or Attending Phy within 24 hours after death. To the Funerel Director: After thi completely filled in by the funeral (Medical ((Check only Medicel Exeminer: On	To the best of my knowledge the basis of examination ar manner stated.						
	To t To t	M	29b. Signature and title of certifier	a phai	cii	29c. License r	number ~976	9	1. Date signed (Month)	Pey, Year)
	4		30. Name and addless of person who completed	cause of death (Item 23a)	(Туре,	Print)	// \.	21 1	N. 1/2 /2 /	21228
\	Sta Regist		31. Date filed (Month, Day, Year) NOV 1 8 2004	32, Registrar's Signature	7	hair -	olling		WILD AN	- 1000
				Contract of the second	-					

DHMH 17 Rev 1/2001

ORIGINAL

			For State Registrar	State o	of Marylar	nd / Depa	artment of H	lealth a D <i>eath</i>	ind M	ental Hy	rgiene2 (004	36538
			1. Decedent's Name (First, Middle,	Last)						2. Date of De		V	3. Time of Death
	Physicia /Modic		Ernestine		T.		Robinson	1		11	13 20	004	11:07p ^M
	/Medic Examin		4a. Facility Name (If not institution,	give street and nu	mber)	, ,	4b. City, Town, or	Location of	f Death		4c. Coun	ty of Death	
			university Sp	ecialty	HOSF	ortal	Balt	imore				N	A
	Funeral		5. Social Security Number	6. Sex	7. Age (In yrs.	last birthday)	If Under 1 Year Months Days	If Under 2 Hours	24 Hrs. Min.	8. Date of Bi (Month, D	rth av Year)	9. Birth	place (State or Foreign intry)
	Director		220-05-1744	1 □ M 2 □ X	92	Yrs.	Worldis Days	Hours	WINT.	1-1	7–12	000	N.C.
	p.		Usual Residence of Decedent		100 0	n. Town and							40.1.1.1.00.11.10.
	ahow del	-	10a. State 10b. County		100. 01	ty, Town or Lo							10d. Inside City Limits 1 ☑ Yes 2 ☐ No
1	8a-1 a	cto	Md.	NA		Bal	timore						
76	ith th	i i	10e. Street and Number	G1	3 In	1106	10f. Zip Code	1201			10g. Citizen o	f What Cou USA	ntry?
nestin	death with the Maryland ims 23a or 28a-1 ahow r roust be notified at	Funeral Director	124 W. Franklir		Apt.			1201					
+	ar de tams	nue	11. Marital Status	Armed Fo		I.S. 13.	Was Decedent of H If Yes, specify Cuba	ispanic Orig ın, <mark>Me</mark> xican,	gin? (Spe , Puerto F	cify Yes or No Rican, etc.)	0- 14. H	ace - Ameri ack, White,	
30 00	s after , or Ita	by F	1 ☐ Never Married 2 ☐ Marrie 3X ☐ Widowed 4 ☐ Divorced	ed 1 Tes If Yes, Gi Year or D	ive X No		1☐Yes 2【XNo	Specify:			Spec	ity:	Black
Trne 215-0036	within 72 hours after death with the Marylar ene. than "natural", or Itams 23a or 28a-1 ahow he Madical Examitter must be multified at	ed t	15. Decedent		74163.	16a Dece	dent's Usual Occup	ation			16b. Kind of		
17 5	in 72	jet	(Specify only highes	t grade completed)		(Give	kind of work done of DO NOT use retired	during most	of working	ng			,
212	with iene. than	E	Elementary/Secondary (0-12)	College (1-4or 5+)		usekeepin				Nursi	ng Ho	me
	filed Hygid other ant,	Be Completed	17. Father's Name (First, Middle, I	.ast)				18. Mother	r's Name	(First, Middle	, Maiden Suma		
S lan	lid be lental kad c	To B	Henry		Thro	wer			Jane		Ed	monds	on
\mathcal{SON} aryland	permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 Is marked other than any injury or other traumetic event, the Mones.	-	19a. Informant's Name/Relationsh	nip (Type, Print)		19b. Maili	ng Address (Street	and Number	r or Rura	Route Numb	er, City or Tow	n, State, Zij	p Code 1216
ΣŽ	1 and 2 Health a am 27 Is		Larry Keaton	grands	on		2503 Wind	heste	r St	. Apt.	203, B	altim	ore, Md.
~ 5 ē	s 1 au of Hea itam otha		20a. Method of Disposition			Place of Dispo	osition (Name of matory or other place	(a)	D	ate	20c. Location	n - City or T	own, State
√5 E	Pages nent of int: If it iry or o		1 Burial 2 □ Cremation 1 □ Donation 5 □ Other (Sp		State	ing Me			11-19	9-04	Randal	lstow	n, Md.
Baltii	permit. Pages 1 Department of F Important: If its any injury or ot ones.		21. Signature of Funeral Service L	•			2. Name and Addres						Md. 21202
ä	Depar Impo any ir		& lander	0 142	anne -		March F.H	l. Eas	t .	1101 E	. North		
			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that	caused the dea	th. Do not en	ter the mode of dyin	g, such as o	cardiac or	respiratory a	arrest,		Approximate Interval Between
	Physician		Immediate Cause (Final	orly one cause on	oron	avy	$\alpha \sim$	ter	4	dino	ase		Onset and Death
	/Medical		disease or condition resulting in death)	a Due to	(or as a consec		α,	1	/	2.1.5			7 1
	Examiner			I. H	Yper	tens	ion						725.
		ē	Sequentially list conditions,	b. Due to	(c) as a consec	. ,							
V.1	outed	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	c.	Seizu	re	disor	der					Y23.
ó	te be executed ysician and		resulting in death) Last	Due to	(or as a consec	quence of):							
760,	ite be iysici	icai		d									
P.O. Box 68	leath certifica attending ph I for use as tl	Jed	IF FEMALE:		·								
XO	th ce lendii r use	an/h	23b. Was decedent pregnant		tcome of pregn		☐Ectopic pregnancy	,				ate of deliv	,
В.	ne dea the att hed fo	sicia	in the past 12 months? 1 Yes 2 No	4□Preg 9□Unkr	nant at time of o		Other (specify)				, n	MORITI	Day Year
ρ.Ο	that the de ed by the detached	by Physician/Med	9 Unknown	1						00.00			
	es tha igned be de	b	Part II. Other significant condition	ns contributing to c	death but not res	sulting in the u	inderlying cause giv	en in Part I.					the cause of death?
ord	v requir been si should	ted								10	Yes 2∐No	3 Pro	bably 4. Unknown
ecc	law re as be	Completed					<u> </u>			24a. Was	psy	prior to co	opsy findings available ompletion of cause of
E	The late hapage	No.								1 Yes	2 No	death? 1 ☐ Yes	2 🗆 No
ita	ician: certifical ector, p	Be (25. Was case referred to medical examiner?				,	26. Place	of Death	(Check only	one)		
Ž	Phyaic this ce al dire	2	1 ☐ Yes 2 ☑ No] ER/Outpatie	nt 3□ DOA Oth	er: 4 🗆 Nur	rsing Hon	ne 5□Res	idence 6 🗆 O	ther (Speci	ty)
Division of Vital Records,	ding Phyaician: n. After this certific funeral director,		27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date (Mor	of Injury oth, Day Year)	28b. Time o Injury	Wor			8d. Describe	how injury occi	urred	
oi o	uttendii death. ctor: A y the fu	cati	2 Accident investig	jation				Yes 2□N					
Ξ	ter d iract iract	Certification;	4 Homicide determ	ned 280. Plac	e of Injury - At h ling, etc. (Speci	nome, farm, st	reet, factory, office		2		(Street and Nun wn, State)	nber or Rur	al Route Number,
	urs al								11/				<u> </u>
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funaral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	edical	(Check only 2 Medicel I	Exeminer: On the b	basis of examina		th occurred at the tin estigation, in my o						
	tha hin 2 the mple	Med	29b. Signature and title of certifier		nner stated.		29c. Licens	e number			29d. Date sign	ned (Month	Day Year)
	To To		▶ CfMel	ta MD			7	34	97		N/01/	15	2004
							D	J 4	' /		1000.		2004
	1-		30. Name and address of person CHARY MEH		ise of death (Ite	m 23a) (Type,	h charle	es st	ree	A Ba	ltimor	Q,n	1021230
	© Sta	ato	31. Date filed (Month, Day, Year)		Registgar's Sign	ature	At comment		4,		· · · · · · · · · · · · · · · · · · ·		
	Regist		NOV 1	8 2004		w /	5 Som	May.					

			State Amend Item 28	Bf per ME,	3837,117	8/04dbb ertificate of	Death	P	leg. No. 201	04 36539
	Physicia		1. Decedent's Name (First, Middle, La					2. Date of Dea Month	Day	3. Time of Death
7.7 7.75 1.75	/Medic	al .	Douglas Jame			th City Town	- Logation of Dogs	Nov	5 Zc	04
	Examin	er	ta. Facility Name (If not institution, giv			1	Location of Deal	(m	How	_
	F	7.	10659 High Beam (5. Social Security Number 6. S		(In yrs. last birth	Columb day) If Under 1 Year	If Under 24 Hrs	8. Date of Birth	1	9. Birthplace (State or Foreign
	Funeral Director		145-46-1598	X □M 2□F	50 Y	s. Months Days	Hours Min	Sep 28		New Jersey
3	2		Usual Residence of Decedent		10c. City, Town	v. Location		*		10d. Inside City Limits
-	shov	_	10a. State 10b. County							1 ☐ Yes 2V No
7	28a-f	ecto	Maryland Howard	1	Colu	IDLA 10f. Zip Code			10g. Citizen of Wh	nat Country?
4	WIII	흡	10659 High Beam	Court		210	44		USA	,
4	ms 23	Funeral Director	11. Marital Status	12. Was Decedent E	ver in U.S.	13. Was Decedent of H	ispanic Origin? (5	Specify Yes or No-	14. Race	- American Indian,
Maryland 21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. if the Arth and Mental Hygiene. other traumatic event, the Madical Examiner must be radiitied at	þ	Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 ☐ N If Yes, Give A Year or Dates:	0	If Yes, specify Cuba	яп, мехісап, гиел Specify:	to rican, etc.)		, White, etc. White
	72 ho	Completed	15. Decedent's E (Specify only highest gra	ducation	16a. [ecedent's Usual Occup Give kind of work done	ation during most of wo	orking	16b. Kind of Bus	iness/Industry
2	ithin ee.	nple	Elementary/Secondary (0-12)	College (1-4or 5-	-1	ife. DO NOT use retire	d)		Devel	C D C
2	e tiled within al Hygiene. I other than " vent, Ite Me		17. Father's Name (First, Middle, Last	5+	<u> </u>	lectrical E		me (First, Middle,		f Defense
and	ntal H ed ot ed ot	Be						ry Schlo		,
2	2 should be to and Mental It is marked of raumatic eve	2	Reino E. Rahikka		19b. I	Mailing Address (Street				tate, Zip Code)
<u>≅</u> 3	nd 2 s lth an 27 ls r trau		Robert Rahikka /			369 New Cou				
<u>ရ</u> ်	os 1 and 2 of Health item 27 I	li	20a. Method of Disposition		20b. Place of 0	Disposition (Name of crematory or other place		Date		city or Town, State
Ë,	Page ent o nt: If ry or		1 ☐ Burial 2 X Cremation 3 ☐ 14 ☐ Donation 5 ☐ Other (Speci			Crematory		06/04	Baltimo	re, Maryland
Baltimore,	permit. Pages 1 Department of H Important: If ite any injury or ot once.		21. Signature of Funeral Service Liop Thomas Gregor	Juga-		22. Name and Addre Cremation 200 Freder	ss of Facility Society	Of Maryl	and Inc.	land 21228
k_{-j}	5 - TA -		23a. Part1. Enter the disease, or com	plications that caused	the death. Do no					Approximate Interval Between
F	Physician		shock, or heart failure. List only Immediate Cause (Final disease or condition			nd to the	ehead			Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a	consequence of):				
186×1	LAdiminer	_	Sequentially list conditions,	U	SSION):				years
	pet Insit	niner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury			,				
,	execu n and ial-tra	Exami	that initiated events resulting in death) Last	Due to (or as a	consequence of):				
8760	The law requires that the death certificate be executed sie has been signed by the attending physician and page 2 should be detached for use as the burial-transit	dical	(_ d						
89	ntifical og ph as th		IF FEMALE:							
Вох	eath certific attending p	lan/M	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of	2 🗌 Fetal death	3 Ectopic pregnancy	/		23d. Date Mont	of delivery h Day Year
0.	at the dea by the at tached fo	Physicia	1 Yes 2 No	4□Pregnant at 9□Unknown	time of death	5 ☐ Other (specify) _				
<u>a</u> .	that if led by detac		Part II. Other significant conditions	contributing to death bu	at not resulting in	he underlying cause giv	en in Part I.	23e. Did to	bacco use contrib	oute to the cause of death?
ds,	sign sign d be	d by		_				1 □ Y	′es 2 □ No 3	3 ☐ Probably 4 ☑ Inknown
Records,	w requir been si should	Completed						24a. Was	an 24b. W	ere autopsy findings available
Be	The law cate has page 2	E C						autop perfor	rmed? de	ior to completion of cause of eath? □ Yes 2 □ No
		O I	25. Was case referred to medical				26. Place of De	ath (Check only or		
<u> </u>	S = 5	To B	examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 Inpatie	nt 2□ER/Out	patient 3 DOA	ner: 4 ☐ Nursing	Home 5 Resid	lence 6 Other	(Specify)
n of	ding Ph h. After thi funeral		27. Manner of Death 1 □Natural 5 □ Pending	28a. Date of Injur (Month, Day	y 28b. Ti	ury P Wo	rk?		low injury occurre	
Sio	uttsndii death. ctor: A r the fu	cati	2 Accident investigation 3 Suicide 6 Could not l	MCV 212	004 ~ 1º	1	Yes 2 MNo			otgun to head
Division	or Att	Certification:	4 Homicide determined	building, etc	iry - At nome, fari c. (Specify)	n, street, factory, office		City or Tow	m, State) 106	r or Rural Route Number, 59 High Beam Cl
_	To tha Hospital or Attendii within 24 hours after death. To tha Funeral Diractor: A completely filled in by the fu	Medical Ce		hysician: To the best of miner: On the basis of	examination and					
	thin 2 tha	Med	29b. Signature and title of certifier	and manner sta		29c. Licens	se number		29d. Date signed	(Month, Day, Year)
	⊬ક⊭ઇ		1/2	1.0	ME	D2	1473		Nov	6,2004
			30. Name and address of person who	completed cause of de	eath (Item 23a) (ype, Print)	. 7 . 7	_		21042
			PATRUCE A	ote mo	4565		ck Cone	Way F	Flhiat	City MY
0.00	THE RESIDENCE	-	31. Date filed (Month, Day, Year)		ar's Siggature	1		_)		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygier O.O. I.

			For State Registrar	State of Mary	nand / De C	partment of H ertificate of I	eaith and M Death		ene 0 0 4	36540
			1. Decedent's Name (First, Middle, Las)				2. Date of Death Month	Day Year	3. Time of Death
	Physicia /Medic		Anthony Rojas						09, 2004	15:35 M
}	Examin		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, or	Location of Death		4c. County of Death	
			524 North Charles	Street #21	12	Bal	timore			
	Funeral Director		303-40-3703	x 7. Age (li XM 2□ F	n yrs. last birthdo 70 Yrs	Months Davs	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, July 20,	9. Birth Con 1934	nplace (State or Foreign untry) unk
	yland		Usual Residence of Decedent 10a. State 10b. County	10	c. City, Town or	Location				10d. Inside City Limits
	se-fsh	ctor	MD		Balti					1 Yes 2 No
	th with the 23a or 2	al Dire	10e. Street and Number 524 N. Charles			10f. Zip Code	21201	10	g. Citizen of What Col USA	-
036	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or Items 23a or 28e-f show or other treumetic event, the Madical Exaciliser rust be malified.	Completed by Funeral Director	11. Marital Status UNK 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Eve Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:	rin U.S. 1 unk	 Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2X No 	ispanic Origin? (Spe n, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race · Amer Black, White Specify: W	
5-0	"natur	etec	15. Decedent's Ed (Specify only highest grad	ucation de completed)	16a. De	cedent's Usual Occup- ive kind of work done of b. DO NOT use retired	ation during most of worki	unk 1	6b. Kind of Business/l	ndustry unk
21215-0036	ed within rgiene. er then i, Ine Mi	Comp	Elementary/Secondary (0-12) unk t	College (1-4or 5+) ink		3. DO NOT use retired				
land	12 should be filed within h and Mental Hygiene. 7 is marked other then "Ireumetic event, Ire Mac	To Be	17. Father's Name (First, Middle, Last)			unk	18. Mother's Name	(First, Middle, M	aiden Sumame)	unk
, Maryland	and 2 shou alth and M 127 is mar er treumet		19a. Informant's Name/Relationship (7 O $ \bullet C \bullet M \bullet E \bullet$	ype, Print)	1	ailing Address (Street a. 1 Penn Str				ïp Code)
Baltimore,	permit. Pages 1 and 2 Department of Health a Importent: If item 27 is any injury or other tre		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ '4 ☐ Donation 5 🖔 Other (Specify	Removal from State	cemetery, o	sposition (Name of crematory or other place	θ)		Oc. Location - City or 1	
Balt	permit. Pa Departmen Importent: any injury once.		21. Signature of Funeral Project Licent	Wade irec	tor	22. Name and Addres State Ana Baltimore	tomy Boar, MD 212	d 655 W.	Baltimore	Street
	Pnysician /Medical Examiner	10	23a. Part Enter the disease, of coring shock or heart failure. List only of immediate cause (Final disease or condition resulting in death) Sequentially list conditions,	one cause on each line.	onsequence of):	enter the mode of dyin				Approximate Interval Between Onset and Death
68760,	lificate be executed g physician and as the burial-transit	edical Examiner	Sequentially list conditions, if any, Jading to immodiate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	C. Due to (or as a co						
.O. Box (death cer e attendin d for use	Physiclan/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of p 1 □ Live birth 2 □ 4 □ Pregnant at tim 9 □ Unknown	Fetal death	3 □Ectopic pregnancy 5 □ Other (specify)			23d. Date of deliment	very Day Year
Ω_	requires that the de een signed by the a nould be detached f		Part II. Other significant conditions co	ontributing to death but n	ot resulting in th	e underlying cause give	en in Part I.		cco use contribute to	the cause of death?
Il Records,	The law ate has b page 2 st	Completed by						24a. Was an autopsy perform 1 🗆 Yes 🏻 2	prior to c	topsy findings available ompletion of cause of
Vital	Physicien: Th this certificate al director, pag	Be	25. Was case referred to medical examiner?	Hospital:		Simulation Other	26. Place of Death			25 (42)
of	Phys this al dii	To	1 Ves 2 No 27. Manner of Death	1 ☐ Inpatient	2 ER/Outpa 28b. Tim	tient 3 DOA	4 Li Nursing Ho	me 5 Residen 28d. Describe hov	ce 6 V Other (Spec	ify) scene
L	D 0 0	lo	1X Natural 5 ☐ Pending	(Month, Day Ye	ear) Injui	y Wor	k? Yes 2 □No	EDG. DESCRIBE NOV	injury occurred	
Division	or Attending ifter death. Director: After in by the fune	Certification;	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury building, etc. (5	- At home, farm, Specify)	street, factory, office		28f. Location (Stre City or Town,	eet and Number or Ru State)	ral Route Number,
_	To the Hospital or Attendin within 24 hours after death. To the Funeral Director: Att completely filled in by the fur	edical Ce	29a. Certifier 1 Certifying Physics (Check only one) 2 Medical Example 1	ysician: To the best of m iner: On the basis of ex and manner stated	amination and/o	eath occurred at the tin r investigation, in my o	ne, date and place, a pinion, death occurr	and due to the cau ed at the time, dat	ise(s) and manner as e and place, and due	stated. to the cause(s)
)	To the To the compl	Me	29b. Signature and title of certifier	ene A	9.	29c. Licenso	o.C.M.E.		d. Date signed (Month	
•			30. Name and address of person who	140						
	Sta	ite	31. Date filed (Month, Day, Year)	32. Registrar's		11 Penn St	reet, Bal	timore, 1	Maryland 2	1201
	Regist	ar	NOV 1 8 2004	Semina	B	doorker				

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** Wordson KOLAND /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City_Town, or Location of Death Examiner TAL CENTER BALTINERE ANDAUSTOWN If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. Manth, Day, Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday **Funeral** 216-34 1 M 2 □ F (060 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f ehow other traumatic evant, the Mudical Examiner must be nutitive at 1 ☐ Yes 2 ☑ No Director ta Himore 10f Zip Code 10g. Citizen of What Country? 10e. Street and Number ö Iteme 23a Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Curan, Mexican, Puerlo Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Marital Status 2 No 1 Never Married 2 Married 1 Yes 2 No ŏ Baltimore, Maryland 21215-0036 Specify: Specify: BIAC by 4 Divorced 3 Widowed "netural", Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. ant: If item 27 le marked other than ' Manufactor 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Joseph Smith, Sk.

19a. Inf ant's Name/Relationship (Type, L-dna 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Print) ... Fairview Road, Baltimore, MD mith 20b. Place of Disposition (Name of Date 20a. Method of Disposition cemetery, crematory or other place) Department of Important: If it any injury or o 1 Burial 2 Cremation 3 Removal from State Greenmount 11-22-04 baltimore 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Greene Furtheral Since Grown, mo Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) SEPSIS **Physician** /Medical Due to (or as a consequence of): **Examiner** KLEBSIERA DIVEUMBNIKE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Be Completed by Physician/Medical Examiner the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) P.0. detached 9☐ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, OBSTRUCTIVE SLEEPANKEA; CHAONIC OBSTRUCTIVE LING DISTRU 1 ☐ Yes 2 ☐ No 3 ☐ Probably CARDIONGOPATHY, CONGESTIVE HEART FAILURE, RESPIRATOR FA 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 100 24a. Was an ACUTE ON CHAONIC RENAL TACKERE! DIABETTS 1 ☐ Yes 21000 Division of Vital To the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Impatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 ☐ Yes 2 ☐ No 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 5 Pending investigation 1 Natural 1 🗌 Yes 2 🗌 No 2 Accident after death Director: 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide within 24 hours after To the Funeral Dir 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier HOVEMBER 17 2004 VORTHWEST HOSPITHL CONTOR 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) B. CONANTAN MED RANDALISTOWN. ORLANDO 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Gapen NOV 1 8 2004 Registrar

State of Maryland / Department of Health and Mental Hygieney Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month V **Physician** 5WANSON 0402 M KAREN 2004 /Medical 4c. County of Deeth 4b. City, Town, or Location of Death 4a. Fecility Name (If not institution, give street and number) Examiner Regional Hospital Laurel Prince George's Laurel If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, April 27 Birthplece (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1 ☐ M 2 💢 F 36 Maryland Director 213-60-7434 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County s 23a or 28a-f show Laure1 1 ☐ Yes 2 X No Maryland Prince Georges Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20708 United States 8464 Snowden Oaks Place Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married ŏ 1 ☐ Yes 2 🗓 No Baltimore, Maryland 21215-0036 Specify: Specify: white Completed by 3 Widowed 4 Divorced "natural" 16b. Kind of Business/Industry 16a, Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within; Department of Health and Mental Hygiene. Important: if item 27 is marked other than 7 any injury or other traumetic event, the Mad once. College (1-4or 5+) Elementary/Secondary (0-12) own home homemaker 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Richard Stephen Frank Nancy Sheridan Dempster 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Laurel, MD 20708 8464 Snowden Oaks Place Edward Swanson/husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 XCremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Greenmount Crematory Nov. 18,2004 Baltimore, Maryland Name and Address of Facility
Mitchell-Wiedefeld Funeral Home, Inc.
6500 York Rd. Baltimore, MD 21212 21. Signature of Funeral Service Licensee Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shack, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Alcoholic Liver Pisease Mon th Pnysician /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician by Physician/Medical 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy Year Month Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? stension 24a. Was an autopsy performed? Yes 2 No 1 Yes 2 No 1 Yes in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1-Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Yeer) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 5 Pending Matural 1 ☐ Yes 2 ☐ No investigation 2 Accident death after death 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Hospitel 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier NOU 17-2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 554121 MA 9101 CHERRY (= well M) LANE SHITE 211 31. Date filed (Month, Day, Year) 32. Registrar's Signature State WOW 1 8 2004 oaks Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 04 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Day SHANNON MARIE NOVEMBER - 16 -2004 4:28 PM /Medical Examiner 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death HOSPITAL CENTER BALTIMORE HARBOR If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 💢 F 212-56-280 Director MARCH 2,195 Usual Residence of Decedent death with the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits r then "naturel", or Items 23a or 28a-f shov the Medical Expedient must be rediffed at Funeral Director 1 🗷 Yes 2 🗌 No MARYLAND 10e. Street and Number 10f. Zip Code og. Citizen of What Country? USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Completed by 3 Widowed 4 Divorced ACK 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b, Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 HHGRADE Pages 1 and 2 should be filed w then of Health and Mental Hygiei rtant: If item 27 is marked other ti jury or othar treumatic event, III 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) WILLIE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ROLLING RD. ICHARD SHANNON ROTHER PALTIMORE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Department of Important: If eny injury or once. ZION CEMETERY 11-19-04 4 ☐ Donation 5 ☐ Other (Specify) LANSDOWNE, M.D. 22. Name and Address of Facility 21. Signature of Funeral Service Licensee BROWNUR, FUNERAL HOME FULTON AVE BALTO MO, 21217 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pnysician HEPATORENAL SYNDROME DAYS /Medical Due to (or as a consequence of): Examiner OF CRYPTOGENIC LIVER CIRRHOSIS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner ig physician and as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE use a 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 3 Ectopic pregnancy jo in the past 12 months? Year Month Day 4☐Pregnant at time of death 5 Other (specify) P.O. the Š signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Be Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? . page 2 autopsy performed? certificate Division of Vital 1 Yes 2 🗷 No 1 Yes 2 No Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death Check on one examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 No 1 ☑Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this funeral of 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident within 24 hours after death To the Funerel Director: completely filled in by the 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 🖎 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier WD OOORES NOVEMBER - 16 - 2004 30. Name and add s of person who completed cause of death (Item 23a) (Type, Print) S. HANOVER STREET, BALTIMORE MD 21225 3001 MARKANDAYA HTANULNAM 32, Registrar's Signature 31. Date filed (Month, Day, Year) State NOV 1 8 2004 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 2004 Howard Smothers 36544 For State Registrar 04 - 7368Certificate of Death Reg. No. 1 Decedent's Name (First Middle Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** omothers 10:08 PM oward November 15, 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Baltimore University Hospital 7. Age (In yrs. last birthday) 39 Yrs. 8. Date of Birth (Month, Day, Jun. 26, Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** Year) 65 1 M 2 □ F Months -92-123 Director maryland Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 27 is marked other than "natural", or items 23a or 28e-f show treumetic event, the Medical Evantiner must be notified at 1 Yes 2 □ No Baltimore Director NIA MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code with Ser 21214 USA Ave ton death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 72 hours after 1 Never Married 2 Married 1 Yes 2 No Baltimore, Maryland 21215-0036 by Specify. Specify: Black Yes. Give If Yes, Give Year or Dates: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry be filed within 7 al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) andscaping 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 1 and 2 should be file Health and Mental Hy Iem 27 Is marked oth Be SR. Smothers atherine Melvin 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Serton Ave Baltimore, mb 21214 item 27 Catherine Smother other 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 □Removal from State ö Department of Important: If any injury or once. Metro atonsville ⁴ 4 □ Donation. Other (Specify) Cremator 21229 neral S 22. Name and Address of Facility 21. Signature wice Licen PASS BALTO, MI t interdisease, of complications that cause the death. Do not enter the mode of dying, such as cardiac or respiratory arrest 23a. Party E shock or Approximate Interval Between Onset and Death Immediate duse (Final disease of condition resulting in death) Physician /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions Due to (or as a consequence of) Physician/Medical Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last the burial-transit VA. Due to (or as a consequence of): Box 68760. physician death certificate be use as t attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year Day for in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) P.O. ed by the a detached f 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. ₽ be 1 🗌 Yes 2 No 3 Probably 4 Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy performed 2□ No 2 No Yes Yes To the Hospitel or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 1 🗌 Inpatient 2√2 ER/Outpatient 3 DOA 6 Other (Specify) dir 2 XXYes 2 No 4 Nursing Home 5 Residence this Date of Injury (M Inth, D 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After 1 Natural 5 Pending investigation No 104 1 TYes 2 Accident after death Director: / d in by the f At home 6 ☐ Could not be 3 Suicide e o Injury Atding, etc. (Spe 28f. Location (Street and Number or Rural Route Number, City or Tolm, State) street, factory, office determined uilding, etc. 4 Homicide in 24 hours. the Funerel Dire 000 HO M 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie Medical one within 2 and title of certifier 29d. Date signed (Month, Day, Year, 29c. License number 29b. Signa November 16, 2004 O.C.M.E. completed cause of death (Item 23a) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201 M 32. Registrar's Signature 31. Date filed (Month, Day, Year) State NOV 1 8 2004 Registra

			For State Registrar	State of Maryla		artment of I		Mental Hy	/giene 200 L	36545
	Physici /Medic Examin	al	Decedent's Name (First, Middle, Last, Lillian B. So Aa. Facility Name (If not institution, give	chemm street and number)			or Location of Dea	2. Date of D Month	Day Year 3 300 4c. County of Dee	
	Funeral Director		Genesis Eldercare 5. Social Security Number 212-30-2828 Usual Residence of Decedent		s. last birthday) Yrs	Balti If Under 1 Year Months Days	MOTE If Under 24 Hr Hours Mir		rth 9. Bir	rthplace (State or Foreign ountry) ryland
	filed within 72 hours after deeth with the Maryland Hygiene ther than "naturel", or flems 23a or 28e-f show with it a Medical Eval wr must be inciffed at	Director	10a. State 10b. County Maryland Anne Art 10a. Street and Number		Glen Bi				10g. Citizen of What C	
036	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "naturel", or flems 23a or 28a-f show any injury or other traumatic avent, if a Medical Evaluities in must be inclined at Once.	by Funeral	122 Ilene Road 11. Marital Status 1 □ Never Married 2 □ Married 3 ★ Widowed 4 □ Divorced	12. Was Decedent Ever in Armed Forces? 1 Tyes 2 TM No If Yes, Give Year or Dates:		Was Decedent of I If Yes, specify Cub 1 ☐ Yes 2 H No		Specify Yes or N no Rican, etc.)	United Storm 14. Race - Am Black, Whi	erican Indian, te, etc.
121215-0036	iled within 72 ho Hygiene. ther then "natu nt, I're Medical	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)	cation e <i>completed)</i> College (1-4or 5+)	(Give	dent's Usual Occup kind of work done DO NOT use retire	during most of w		Own Home Maiden Sumame)	v/Industry
Maryland	nd 2 should be f lith and Mental H 27 is marked of r traumatic ave	To Be	John J. Kroth 19a. Informant's Name/Relationship (Ty Betty Schemm/Daug)			ng Address (Street	Ann	a Geisle	•	Zip Code)
Baltimore,	mit. Pages 1 ar partment of Hea portent: If item injury or othe		20a. Method of Disposition 1 Purial 2 Cremation 3 F 4 Donation 5 Other (Specify) 21. Signature of Furieval Service Licens	Removal from State G]	cemetery, cre en Have	esition (Name of matory or other pla en Mem. P	k. 16,	EMBER 2004 neral Ho	Glen Burrome P.A.	
B	Physician		23a. Part 1. Enter the disease, or compleshock, or heart failure. List only of Immediate Cause (Final disease or condition	ications that caused the dene cause on each line.	42	21 Crain	Hwy. S.E	. Glen I	Burnie, MD	21061 Approximate Interval Between Onset and Death
8760, 5	(Medical Examiner Assistance)	icai Examiner	resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a const		Hon	Droe	Faul		87201
P.O. Box 68	e death certif he attending ed for use a	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 XNo 9 □ Unknown	23c. If yes, outcome of preg 1 ☐ Live birth 2 ☐ Fe 4 ☐ Pregnant at time of 9 ☐ Unknown	etal death 3	Ectopic pregnanc Other (specify)	у		23d. Date of de Month	livery Day Year
	requires been sign bould be	Completed by Pl	Part II. Other significant conditions co	ntributing to death but not r			en in Part I.			o the cause of death? robably 4 □Unknown utopsy findings available
Vital Records,	Physicien: The law this certificate has t ral director, page 2 s	Be	25. Was case referred to medical examiner?	Josephali		0.1		auto	opsy prior to death? 22 No 1 Yes	completion of cause of
Division of \	ding Phy n. After this funeral d	Certification: To	1 Yes 2 No ' 27. Manner of Death 1 Natural 5 Pending investigation 3 Suicide 6 Could not be	lospital: 1 ☐ Inpatient 2 28a. Date of Injury (Month, Day Year)	28b. Time o Injury	f 28c. Inju Wo	ry at	28d. Describe	idence 6 ☐ Other (Spe how injury occurred	
Divi	To the Hospitel or Attencythin 24 hours after death To the Funerel Director; completely filled in by the	edical Certifi	4 Homicide determined	28e. Place of Injury - At building, etc. (Spe sician: To the best of my kner: On the basis of exami	cify)		me, date and plac	City or To	(Street and Number or Riwn, State) cause(s) and manner a date and place, and du	
	To the Hospitel within 24 hours a To the Funerel E completely filled	-5	one)	and manner stated.		29c Licens	se number		29d Date signed /Mog	th Day Year)
	Sta	ite	30. Name and address of person who con the control of the control	ompleted cause of death (IIII) 80 2 32. Registrar's Sig	em 23a) (Type,	Print) 24/R ld	y PAS	ADRNA	MD 21	122
	Regist	ar	NUV T 8 2	UU4 Zalesa	10. 1	CASSAGE !				

State of Maryland / Department of Health and Mental Hygienes For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 16, 2004 3:15P M Frances M. Skewers Nov. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Long View Nursing Home Manchester Carrol1 If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months i 1 □ M **XX X** F 89 Director 214-03-2639 Oct.8,1915 Maryland Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits 28a-f ahow other traumatic event. the Madical Exeminer must be nutified at XXYes 2 ☐ No Director MD Carroll Westminster 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 0 U.S.A. Items 23g 1309 High Ridge Dr. 21157 Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after Tilled Folces? I □ Yes A\\
If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ō 1 ☐ Yes XXNo Specify: **X**Widowed 4 □ Divorced White "natural" 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Waitress Restaurant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be h and Mental F Theodore Bienert Mary Graczkowska 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 Allan Skewers / Son 1309 High Ridge Dr. Westminster, MD 21157 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Jo I XXBurial 2 Cremation 3 Removal from State ō rtment rtant: I injury c 5. Other (Specify) ⁴ 4 □ Donation Gardens of Faith M.P. 11/20/04 Baltimore, MD perr it.
Dep rtn
Imp rts
any inju Fu ral S ice Licens 22. Name and Address of Facility Eckhardt Funeral Chapel P.A. 21. Signature 11605 Reisterstown Rd. Owings Mills, MD21117 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each t, e. Immediate Cause (Final Pnysician disease or condition resulting in death) /Medical Due to (or Examiner Lunces Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of). use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy įō in the past 12 months? Day Month Year 5 Other (specify) 4☐Pregnant at time of death P.0. detached 9 Unknown à Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by of Vital Records, 99 1 ☐ Yes 2 KNo 3 ☐ Probably 4 ☐ Unknown director, page 2 should Be Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No autopsy perform 2 No 1 Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: ို 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 27. Manner of Death 28a. Date of Injury (Month, Day Yeer) 28b. Time of 28d. Describe how injury occurred Certification: Injury at Work? Division 1 Natural 5 Pending 1 🗌 Yes 2 No 2 Accident investigation within 24 hours after death To the Funaral Director: / 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) ģ 4 Homicide filled in 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier ho completed cause of death (Item 23a) (Type, Print) address of person w 30. Name State NOV 18 2004 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
Amend Items. 7.8. per fh 2845 7-16-05 vt.
State of Maryland 7 Department of Health and Mental Hygiene 2004 36547 Certificate of Death Reg. No. Date of Death
 Month Day Year Physician 15-40 pm 2004 /Medical 4c. County of Dea Examiner If Under 24 Hrs. 8. Date of Birth 1947 (Month, Day, Year) 7. Age (In yrs. last birthday, If Under 1 Year Birthplace (State or Foreign Country) **Funeral** 1 M 2 F Director Sept. filed within 72 hours after death with the Maryland 10d. Inside City Limits or items 23a or 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any njury or other traumatic event, the Medical Examiner rival be confilled at once. 1 Hres 2 □ No Be Completed by Funeral Director 10f. Zip Code 10g. Citizen of What Country? and Number 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 | Yes 2 | No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. 3 ☐ Widowed 4 ☑ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decement's Usual Occupation
(Give kind of work done during most of working if the LBO NOT use dired) UNI Elementary/Secondary (0-12) College (1-4or 5+) 20a. Method of Disposition 20c. Location 1 Burial 2 Cremation 3 Removal from State 4 ☐Donation 5 ☐Other (Specify) 23a. Part1. Enter the disease, or comshock, or heart failure. List only or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest ist only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Priysician Due to (or as a consequence of): vears disease or condition resulting in death) /Medical Examiner morbid obesity year Sequentially list conditions, any same interest underlying cause. Enter Underlying Cause (Disease or injury that initialed events resulting in death) Last Physician/Medical Examiner The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Day Year Month 4 Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy perfor this certificate 2 No 1 Yes 1 ☐ Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 2 X No မ 1 🗌 Yes neatient 2 ER/Outpatient 3□ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28b. Time of Injury 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred Certification: Injury at Work? After 5 Pending investigation Natural death. 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after deat To the Funeral Director: completely filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) ump 18750 10-12-2004 and Blll M completed cause of death (Item 23a) (Type, Print) CHANDA BEIL MD 2012. Univ Par 31. Date filed (Month, Day, Year) 32. Registrar's Signature State NQV 1 8 2004 Registrar

State of Maryland / Department of Health and Mental Hygien 0 0 1 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** 9,2004 10:35 AM SKARUPA JOSHUA November /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner SQUARE BALTIMORE ROSEDALE FRANKlin HOSPITAL If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, NOV . 9, Min. Birthplece (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** ₩ 2□F Hours MD. Director N/A Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location s 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hygiene. The thems 23a or 28e-f show them 52 Te marked other than "natural", or Hems 23a or 28e-f show other traumatic awant, the Modical Exemple minut be inclifted at 1 Yes 2 No Director MD. DUNDALK BALTIMORE 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. 21222 2976 CORNWALL ROAD Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 ☐ Married 1 Yes 2 No Maryland 21215-0036 Specify Specify: WHITE 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) N/A N/A 0 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ANGELA LAWING TODD SKARUPA ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2976 CORNWALL ROAD, BALTIMORE, MARYLAND 21222 t of Health : # Item 27 | ANGELA SKARUPA/MOTHER Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State BALTTMORE WASHINGTON CREMATORY 1 Burial 2 Cremation 3 Removal from State permit. Page Department of Important: if any injury or once. ATORY 11/11/04 LAUREL, AMRYLAND
22. Name and Address of Facility CHARLES S. ZEILER & SON, INC. * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 6224 EASTERN AVE., BALTIMORE, MARYLAND 21224 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician PRETERM DELIVERY /Medical Due to (or as a consequence of): Examiner PRETERM Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequenca of): Examiner The law requires that the death certificate be executed attending physician and for use as the burial-transit CHORIDAMNIONITIS Due to (or as a consequence of): P.O. Box 68760, RUPTURE OF MEMBRANES Physician/Medical ERM use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Year Month Day 4 Pregnant at time of death signed by the ar 5 Other (specify) ☐Yes 2☐No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by Division of Vital Records, 3 ☐ Probably 4 ☑Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has l lirector, page 2 s autopsy performed? 2 No 1 Yes 2 No 1 Tyes Attending Physician: funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Medical Certification: To Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 252 No 1 🔀 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Yeer) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Matural 5 Pending 1 ☐ Yes 2 ☐ No investigation М within 24 hours after death To the Funerel Director: / completely filled in by the f 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Placa of Injury - At home, farm, street, factory, offica building, etc. (Specify) 4 Homicide To the Hospital l 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) 557 NOVembER and address of person who completed cause of death (Item 23a) (Type, Print) , 9000 FRANKLIN SQUARE DRIVE, BALTIMORE, HD 21237 HESSE, M.D Ni COLA 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

State Registrar

NOV 1 8 2004

BABY (

KARUPA

State of Maryland / Department of Health and Mental Hygien 36549 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** DONALD NOVEMBER 09 2004 5:10 P. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MARINER HEALTH OF FOREST HILL FOREST HILL HARFORD If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year, Jan 30, 19 6. Sex Birthplace (State or Foreign Country) **Funeral** Months 1⊠M 2□F 74 216-24**-**9630 Director Maryland Usual Residence of Decedent with the Maryland 10a, State 10b. County 10c. City, Town or Location ral, or Items 23a or 28a-f show Examiner must be notified at 10d. Inside City Limits MD Harford Abingdon 1 ☐ Yes 27 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 32 Boxthorne Road 21009 death Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 2 should be filed within 72 hours after of and Mental Hygiene. is marked other than "natural", or Itel 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Completed by Specify: 3 Widowed 4 Divorced white Year or Dates: 51-53 the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) bricklayer masonery 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be permit. Pages 1 and 2 should be Department of Health and Mental Important: If item 27 is marked of any injury or other treumsets Charles Thomas Emma Bond 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nancy Thomas/spouse 32 Boxthorne Road Abingdon, MD 21009 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State * 4 X Donation 5 ☐ Other (Specify) 21. Signature of Euneral Service Licensee Konald S. Wade 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 Part 1 Enter the disease, ir complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, ir heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Ca' se (Final disease or condition resulting in death) uence of): **Physician** Due to (or as a cons /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter or defining Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. the attending physicien Physician/Medical the IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 4☐ Pregnant at time of death 5 Other (specify) been signed by the should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ğ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? 2√ No 1 ☐ Yes 2 ☐ No 1 Tes or Attending Physicien: funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 1 Yes 2 No this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. injury at Work? 28d. Describe how injury occurred After 5 Pending Natural 1 ☐ Yes 2 ☐ No 2 Accident investigation within 24 hours after death To the Funerel Director: 6 Could not be determined 3 Suicide 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O32255 Wovenby 5 7004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Relair DAV. D 5 LISW 31. Date Conth, Dy, Registrar's Signa State Registrar Darker

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Helen Morningstar Tullis 1:00 a M Nov. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Bonds Forest Assisted Living Finksburg Carroll If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. A DTT1 Day Year 906 7. Age (In yrs. last birthday) 98 Yrs. 5. Social Security Number 6. Sex 9. Birthplace (State or Foreign Mary Land Funeral Months 1 □ M 2 0 F 215-30-1987 Director Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location ?7 is marked other than "natural", or items 23a or 28a-f show traumatic event, I'ls Madical Exartains triust by tradified at 10d. Inside City Limits 1 TXYes 2 □ No Maryland Directo Baltimore Reisterstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 78 Hanover Rd. 21136 U.S.A. by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Item any Injury or other traumatic event, I've Medical Exertains once. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify. White 3 □ Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Housewife Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) William Robert Morningstar Mary Angela McCardell 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Mary Jo Kobosko - daughter 78 Hanover Rd. Reisterstown, Md. 21136 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Evergreen Mem. Gardens Nov. 20,2004 Finksburg, Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Ckhardt Funeral Chapel P.A. 1605 Reisterstown Rd. Owings Mills, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line Approximate Interval Between Opset and Death Immediate Cause (Final disease or condition resulting in death) **Ph**ysician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner led by the attending physician and detached for use as the burial-transit Due to (or as a consequence of) P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months' 1 ☐ Yes 2 ☐ No Month 4☐Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ 1 ☐ Yes 3 Probably 4 DUnknown Completed 24b. Were autopsy findings available prior to completion of cadse of death? 24a. Was an After this certificete has autopsy performed Lins 1 Yes 2 Z No 1 Tyes To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifice 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Cther: 4 ☐ Nursing Home 5 ☐ Residence 6 Ø Other (Specify) 1 Yes 2 No 1 🗌 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) Certification: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending Injury 1□Yes 2□No 2 Accident investigation М 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only onel 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dav. Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 114 Bushess Jonathan Jushne 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar NOV 1 8 2004

		1 - For State Registrar	State of Maryland / Department of Health and Certificate of Death	Mental Hygien 2004 36551
	sician edical	1. Decedent's Name (First, Middle, La	Thompson	2. Date of Death Month Day 2004 1/45 M
	miner	4a. Facility Name (If not institution, gi	ve street and number) 4b. City, Town, or Location of Dea	th 4c. County of Death Baltone
Fune Direct			Sex 7. Age (In yrs. last birthday) If Under YYear If Under 24 Hrs. Months Days Hours Min	
S laryland		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Location	10d. Inside City Limits 1 X Yes 2 □ No
with the M	Funeral Director	10e. Street and Number	$\frac{10f. Zip Code}{2072}$	2 10g. Citizen of What Country?
0 4 or death v	unerai	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (If Yes, specify Cuban, Mexican, Pue	Specify Yes or No- rto Rican, etc.) 14. Race - American Indian, Black, White, etc.
0036 hours afte	ed by F	1 Never Married 2 Married 3 Widowed Divorced	Il Yes 2 No If Yes, Give Year or Dates: ducation 16a. Decedent's Usual Occupation	Specify: Black
21215-0036 21215-0036 solvithin 72 hours after death with the Maryland giene. et than "natural; or Items 23e or 28e-1 show	Completed	(Specify only highest g		DIC MAINTEN ONCE
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If team 27 is marked other transmission is the maryla properties.	To Be Co	17. Father's Name (First, Middle, Las	Thompson SR 18. Mother's Na	ame (First, Middle, Maiden Sumame) 2 P I P D D D D
HOWERG Maryland and 2 should be file saith and Mental Hy nazh s marked oth		Tea Informant's Name/Relationship		Rural Roude Number, City or Town, State, Zip Code)
Baltimore, Maryland permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If them 221 is marked other permiters of the permiter o		20a. Method of Disposition 1 Burial 2 □ Cremation 3 4 □ Donation 5 □ Other (Spec	□ Removal from State 20b Place of Disposition (Name of cemetery, crematory or other place)	Date 20c. Location - City or Town, State
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		23a. Part1. Enter the disease, or conshock, or heart failure. List onli	mplications that caused the death. Do not enter the mode of dying, such as cardially one cause on each line.	Onset and Death
Physici /Medic Examin	cal	disease or condition resulting in death)	a. WERSTATIC bladder Car Due to (or as a consequence of):	uontri
2 3	iner in	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a consequence of):	
8760, sate be executed anysician and the executed and the	ai Examiner	that initiated events resulting in death) Last	c	
Box 687 eath certificate	2 0	IF FEMALE:	d. 23c. If yes, outcome of pregnancy	and Days of defining
P.O. Bo that the death of	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify)	23d. Date of delivery Month Day Year
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Division of Vital Records, P.O. Box 68 Hospital or Attending Physician: The law requires that the death certific 44 hours after death. Funeral Director: After this certificate has been signed by the attending pr	Somp			24a. Was an autopsy available prior to completion of cause of death? 1 Yes 2 No 1 Yes 2 No
of Vital F Physician: Th	Iuneral director.	25. Was case referred to medical examiner? 1 Yes 2 No		eath (Check only one) Home 5 - Residence 6X Other (Specify)
Sion o tending Pl eath. or: Affer ti	the tunera	27. Manner of Death 1 Natural 5 Pending 2 Accident investigat		28d. Describe how injury occurred
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To the Hospital within 24 hours a To the Funeral	completely filled in by Medical Certifi		Physician: To the best of my knowledge, death occurred at the time, date and plac aminer: On the basis of examination and/or investigation, in my opinion, death occ and manner stated.	curred at the time, date and place, and due to the cause(s)
To the within 2	Two N	29b. Signature and title of certifier	29c. License number DS8303	November (2 204
_	Ø		o completed cause of death (Item 23a) (Type, Print) ALUS UD (60° N. Charles Sir Vsalta	
Re	State gistrar	31. Date filed (Month, Day, Year)	32. Registrar's Signature	

		-	For State Registrar	State of Ma	aryland /		rtment of H tificate of I		Mental Hy	gien Reg. No	/ 1111 Lu	365	52
	Dhusisi		1. Decedent's Name (First, Middle,						2. Date of De			3. Time of	f Death
	Physicia /Medic	al	Philip P 4a. Facility Name (If not institution,	Thoma	5	Sr.	th Oh Town	- Landing of Back	Novem	ber	15,2006		Ам
	Examin	er	Johns Hopkins		MedC	h		LOCATION OF DEAT		40	:. County of Dea	ith	
	Funeral		5. Social Security Number 6		e (In yrs. last b	pirthday)_	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.	8. Date of Bi	rth ay, Year,	9. Bir	thplace (State country)	or Foreign
L	Director		219-18-6521 Usual Residence of Decedent	X	78	Yrs.			SEPT.	20,1	926	MD.	•
	iryland show		10a. State 10b. County		10c. City, To							10d. Inside C	•
	the Ma 28a-1	Director	MD. N/	A	BA	ALTIM	ORE			10a Ci	tizen of What C	1	2 🗌 No
	N with	i Dir	3131 DILLON STR	EET			Tor. Zip Code	21224			.S.A.	ountry :	
	r deati	Funerai	11. Marital Status	12. Was Decedent Armed Forces?		13. W	as Decedent of H Yes, specify Cuba	ispanic Origin? (S In, Mexican, Puer	I		14. Race - Am Black, Whi		
36	rs afte	by Fu	1 ☐ Never Married 2 ☐ Marrie 3 ☐ Widowed 4 ☐ Divorced	1 √Yes 2 1 If Yes, Give Year or Dates:	№ 1946 1954	1	☐ Yes 2☐ No	Specify:				HITE	
21215-0036	be tiled within 72 hours after death with the Maryland ital Hygiene. od other than "natural", or tiems 23a or 28a-1 ehow event, the Medical Examinat russ the modified at	eted	15. Decedent's (Specify only highest	Education grade completed)		(Give k	ent's Usual Occupi	durina most of wo.	rkina	16b. F	(ind of Business	/Industry	
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ر ام	e filed with If Hygiene other tha	Be Co	17. Father's Name (First, Middle, La	ist)			WORKLIK	18. Mother's Na	me (First, Middle	1			ORI .
ylar	should be and Mental a marked o umatic eve	To E	MICHAEL THOMAS						A MAKOW				
Maryland	2 a a a	1	19a. Informant's Name/Relationshi PAT NICHOLSON/D		1			WN AVE.,					4
	ss 1 and of Health item 27 other to		20a. Method of Disposition		20b. Place	of Dispos	ition (Name of atory or other plac		Date		ocation - City or		•
Baltimore,	Pages ment of l tant: If it		1 X Burial 2 □ Cremation 3 1 4 □ Donation 5 □ Other (Spe	cify)	I _	LAWN	CEMETER	Y 11/	18/04		TIMORE,		
Ball	permit. Pages Department of Important: If it any injury or o		21. Signature of Funeral Service Li	th Eva	ns	/		ss of Facility CH ERN AVE .				•	
			23a. Part1. Enter the disease, or c shock, or heart failure. List of	omplications that caused bly one cause on each lin	the death. Do	o not ente	r the mode of dyin	g, such as cardia	c or respiratory a	arrest,		Approximat Interval Bet Onset and	ween
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)		iac a		st					30 M	
ı	Examiner			L SCDG		e or):						UNKN	DWN
	pe tis	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequence	e of):							
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68760,	ificate be executed 3 physician and as the burial-transit	edicai E		d									
_	ertifica ding pt se as ti		IF FEMALE:	23c. If yes, outcome	of pregnancy								
O. Box	that the death certifed by the attending detached for use a	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 Live birth 4 Pregnant at	2 Fetal dea		Ectopic pregnancy Other (specify)				23d. Date of de Month		Year
Ф	s that the	by Ph	Part II. Dther significant condition	s contributing to death b	ut not resulting	j in the un	derlying cause give	en in Part I.	23e. Did	tobacco	use contribute t	o the cause of c	death?
rds	w requires that s been signed b should be deta	ted b							1 🗆	Yes 2	□No 3□P	robably 4 🔽	Jnknown
of Vital Records,	The law ate has b page 2 st	Completed						-	24a. Was auto perfo 1 V Yes		prior to death?	utopsy findings completion of c	available ause of
Vita	sician certifi rector	Be	25. Was case referred to medical examiner?	Hospital:			Oth	or	ath (Check only				
of	ding Phys h. After this funeral di	n: To	1 ☐ Yes 2 ☑ No 27. Manger of Death	28a. Date of Inju		Outpatient Time of	3 DOA 28c. Injun	4 Nursing F	lome 5 ☐ Res 28d. Describe			ecify)	
sion	Attending r death. Sctor: After by the funer	atio	1 Natural 5 Pending 2 Accident investiga	tion	y rear)	Injury		Yes 2 □No					
Division	l or Attendater deatl	ertification;	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin		ury - At home, c. (Specify)	farm, stre	et, factory, office		28f. Location (City or To		nd Number or R e)	ural Route Num	nber,
	Hospita 4 hours Funeral ely fillec	edical C	29a. Certifier 1 Certifying (Check only one)	Physicien: To the best kaminer: On the basis of and manner sta	examination a	lge, death and/or inve	occurred at the tin	ne, date and place pinion, death occu	e, and due to the urred at the time,	cause(s	and manner a d place, and du	s stated. e to the cause(s	5)
	To the I within 2 To the I complet	Me	29b. Signature and title of certifier				29c. License	e number		29d. Da	ate signed (Mon	th, Day, Year)	
)	_		Kristin	D. Hel	m			5000		ni	venk	ur 15,	2004
_	10		30. Name and address of person w	m, 494	oras	ern	Ave, E	Baltin	reve, N	1D	21221	t	
	Sta Registi		31. Date filed (Month, Day, Year) NOV 1 8		ar's Signature	B	Spark	2)					
_						7	7-7-5-7-6						

		-	For State Registrar	State o	f Maryland / Dep <i>Ce</i>	artment of rtificate of		nd Me		ene 0) 4	36553
			Decedent's Name (First, Middle	, Last)					2. Date of Death Month	Day	Year	3. Time of Death
	Physici /Medic		Emmett Varner						NOVEMBE	R 8, 20	004	8:40 A. M
	Examin		4a. Facility Name (If not institution	give street and nu	mber)	4b. City, Town.	, or Location of	Death		4c. County	of Death	1
			MALCOLM GROW ME		TER 7. Age (In yrs. last birthday,		PRINGS,	MD 24 Hrs.	8 Date of Birth	PRINCE		
	Funeral Director		5. Social Security Number 418-26-6370	6. Sex 1-⊠M 2□F	77 Yrs.	Months Day		Min.	8. Date of Birth (Month, Day, Oct. 13	Year 1927	AI	iplace (State or Foreign intry) 3 Dama
			Usual Residence of Decedent									404 1-14-01-11-11-
	ahow		10a. State 10b. County	0 1 -	10c. City, Town or L							10d. Inside City Limits 1 ☐ Yes 2 🗓 No
	r 28a-f show	Director	Maryland Prince	George	oxon l	10f. Zip Code			10	g. Citizen of V	What Cou	
	with t		7231 Roanne Dr	ive		207				U.S.A.		,
	ier death w items 23a iner munt i	Funeral	11. Marital Status	12. Was Dec	edent Ever in U.S. 13.	Was Decedent of	f Hispanic Orig	jin? (Spec	ify Yes or No-	14. Rac	e - Amer	ican Indian,
ø	or ite		1 ☐ Never Married 2 🖔 Marri	ed 1 2 Yes If Yes, Gi	2□No 1962	1 ☐ Yes 2 N		, rueno n	iican, etc.)			
21215-0036	72 hours atter death with the Maryland natural', or items 23a or 28a-f ahow dical Examiner must be multiliad at	d by	3 Widowed 4 Divorced	Year or D	Dates: 1966				1.	6b. Kind of Bu	Whi	
15-	C 2	Completed	15. Decedent (Specify only highes	t grade completed)	(Give	edent's Usual Occ e kind of work dor DO NOT use reti	ne during most	of workin	g '	ob. Kind of bi	1211162241	ildustry
212	I within jiene. r than	Julo	Elementary/Secondary (0-12) 12	College (Master	c Chief	Petty C	ffic	er	Milit	ary	
b	be filed withintal Hygiene. Id other than event, the M	Be C	17. Father's Name (First, Middle,	Last)					(First, Middle, M	laiden Sumam	10)	
Maryland	should be filed withind Mental Hygiene. I marked other than umatic event, the	101	Manton Varner						Estes		~	
Mar	12 sh h and 7 is m traum		19a. Informant's Name/Relations! Christine Varn			Roanne				•	State, Zi	p Code)
e)	s 1 and 2 should be filled if Health and Mental Hygir Item 27 is marked other other traumatic event,		20a. Method of Disposition	er (wire)	20b. Place of Disp	osition (Name of			-	Oc. Location -	City or T	own, State
Baltimore,	8 = 5		1 Burial 2 □ Cremation 4 □ Donation 5 □ Other (S)		State Jefferson	matory or other p Memoria		11/13	3/04 F	Birming	ham.	AL
altir	permit. Page Department o Importent: If any injury or once.		21. Signature of Funeral Service	- 2		2. Name and Add					,	
ä	9 9 m m 9		Donnie	12/	Monu	P.O. Bo	\times 7, Tr	ussv	ille, A	L 35173	3	
			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that only one cause on	caused the death. Do not er each line.	iter the mode of d	ying, such as o	cardiac or	respiratory arre	st,		Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)	a METAS	TATIC CANCER							4 MONTES
	/Medical Examiner		leading in dozuly	Due to	(or as a consequence of):							
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	be executed sicien and burial-transit	Examiner	that initiated events	с.							_	
o,	Attending Physicien: The law requires that the death certificate be executed rideath. rideath. ector: After this certificate has been signed by the attending physicien and by the funeral director, page 2 should be detached for use as the burial-transit.		resulting in death) Last		(or as a consequence of):							
8760,	cate be ex physicien the buria	dica		d								
9 X	eath certifica attending pl	Physician/Medical	IF FEMALE:	23c. If ves. ou	itcome of pregnancy				_	23d. Dat	e of deli	/ADV
Вох	that the death cer ed by the attendir detached for use	clan	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	4□Preg	nant at time of death 5	□Ectopic pregnar □ Other (specify)				Mo		Day Year
P.O.	it the di by the tached	hysi	9 Unknown	9□ Unkr	nown							
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ord	Ben si	ted								s 2X No	3 Pro	
ec	e lawı has b	Completed							24a. Was an autopsy perform	, l i	Were aut prior to co death?	opsy findings available ompletion of cause of
a F	ician: The certificate rector, pag								1 Yes 2	□ No 1	Yes	2 No
Zi.	siciar certif irecto	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	Hospital:	Inpatient 2 ER/Outpatie	ent 3 DOA	Othor.		(Check only one ie 5 ☐ Resider		er /Snec	ifv)
Division of Vital Records,	To the Hospital or Attending Physicien: The I within 24 hours after death. To the Funeral Director: After this certificate hat completely filled in by the funeral director, page	n: To	27. Manner of Death	28a. Date					8d. Describe ho			,,
io	endin sath. or: Aft	Certification:	1 X Natural 5 Pendin investi	gation	,,		☐Yes 2☐N	No OF				
Ιχ	or Atte	rtific	3 Suicide 6 Could 4 Homicide determ	igod 200. Flat	e of Injury - At home, farm, s ding, etc. <i>(Specify)</i>	treet, factory, offic	28	2	8f. Location (Str. City or Town,		er or Rui	ral Route Number,
	To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funer		29a. Certifier 1X Certifyir	a Physician: To th	e best of my knowledge, dea	th occurred at the	time date and	d place a	nd due to the ca	use(s) and ma	nneras	stated
	24 hos 24 hos e Fun etely	Medical	(Check only 2 Medicel one)	Examiner: On the	basis of examination and/or inner stated.	nvestigation, in m	y opinion, deat	th occurre	d at the time, da	te and place,	and due	to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifie	r		. J A	ense number		. 1. 2	d. Date signer	_	
)	1		-VA	10101	102	468	Nov,	6,5	2004
	X		30. Name and address of person				CAE	12	0		C	100
	7 9		Charles Motsin 31. Date filed (Month, Day, Year)		Malcol Registrar's Signatura	m Grow U		ııcal	Center	Camp	Spr:	ing, MD
	St Regist	ate rar	NOV 1 8 20		pera /si	LY TORKEN	•					

State of Maryland / Department of Health and Mental Hygien 36554 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** VAVULITIKY 1140 AM TAM ARA NOVEMBER 16 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner KANDALLS TOWN BALTIMORF NORTHWEST If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) aug. 24, 1936 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) Funeral Months Days Hours 1 M 2 F 68 265-93-5809 **Director** russia Usual Residence of Decedent 10a. State 10b. County 10c, City, Town or Location 10d. Inside City Limits 28a-f shov treumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director BALTIMORE RANDALLSTOWN 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 3606 ANNE HATHAWAY DRIVE #1-B 21133 USA Pages 1 and 2 should be filed within 72 hours after death a nent of Health and Mental Hygiene. ant: If item 27 is marked other then "neturel", or items 23 Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 1 □ Yes 2 1 No If Yes, Give X Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🙀 No Specify. WHITE 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (9 College (1-4or 5+) DIRECTOR RESTAURANT 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ZABARSKY BORIS TANYA (UNOBTAINABLE) 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3606 ANNE HATHAWAY DRIVE #1-B, RANDALLSTOWN, MD 21133 ANATOLI EGOROV / HUSBAND other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1 Department of H Importent: if ite any injury or ot once. 1 X Burial 2 □ Cremation 3 □ Removal from State BALTIMORE HEBREW CEM. 11/17/2004 REISTERSTOWN, MD * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** 9 disease or condition resulting in death) Weeks /Medical Due to (or as a consequence of): Examiner tailun 2 weeks multi organ Sequentially list conditions, if any, leading to animediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner To the Hospitel or Attending Physician: The law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Records, P.O. Box 68760 Completed by Physician/Medical the Se IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Day signed by the at the detached for 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed2 2NNo 1 Yes 1 Yes 2 No Division of Vital 25. Was case referred to medical examiner? To Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 XÑo 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No death. 2 Accident after death Director: 6 ☐ Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by determined 4 Homicide within 24 hours a filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month. Day, Year) 29b. Signature and title of certifier D0059736 Mis 16. Christon 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PEBORAH COURT ROAD NOPTHWEST ItOSFITA 5401 OLD WATSON 31. Date filed (Month NOV 32. Registar's Signature 1 8 2004 State Registrar

			•	1 - For State of Registrar	Marylan	-	artment o tificate			lental Hy	/giene Reg. No	601	14	36555
		Physici	an	1. Decedent's Name (First, Middle, Last)	HELCH					2. Date of D Month	Da	ıy Y	'ear	3. Time of Death
		/Medic		ROSALIE McCORMICK	WELSH		4h Cihi Tou		ition of Death	Novemb	1	7, 200		6:30P M
		Examin	er	4a. Facility Name (If not institution, give street and numb	er)			son	tion of Death			Balt		A
		Funeral		Gilchrist Center 5. Social Security Number 6. Sex 7.	Age (In yrs.	last birthday)	If Under 1 Y	ear If U	Inder 24 Hrs.	8. Date of B	irth			lace (State or Foreign try)
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0		and ***		Usual Residence of Decedent 10a. State 10b. County	10c. Cit	y, Town or Lo	cation						10	0d. Inside City Limits
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639		th with the Maryland 23a or 28a-f show	Funeral Director	10e. Street and Number 209 St Dunstans Road			10f. Zip Cod	^{de} 212	212		10g. C	tizen of Wh	at Coun	try?
	92	after dea or Items	by Funer	11. Marital Status 12. Was Deced Armed Forc 1 Never Married 2 Married 11. Was Deced Armed Forc 1 Yes, Give	es? X No		Was Decedent If Yes, specify 1 ☐ Yes XIX	Cuban, Me	ic Origin? (Specifican, Puerto	ecify Yes or N Rican, etc.)	0-	14. Race - Black, Specify:	White, 6	
70	21215-0036	"natural",	ed b	XXWidowed 4 □ Divorced Year or Date 15. Decedent's Education	85.	16a. D <i>ec</i> e	dent's Usual O	ccupation			16b. H	(ind of Busi	ness/Ind	lustry
300	215	hin 72 ho e. an "natu	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4	or 5+)	(Give life.	kind of work di DO NOT use re	lone du <i>ri</i> ng etired)	g most of work.	ing				
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-	and	d fa	To Be	17. Father's Name (First, Middle, Last) Charles Perry McCormick				18.1		Hines	e, Maluei	(Sumame)		
	Marylan	d 2 should be the and Mental 7 is marked of traumatic every	۲	19a. Informant's Name/Relationship (Type, Pnnt)		19b. Mailir	ng Address (St	reet and A			ber, City	or Town, St	ate, Zip	Code)
~		1 and 2 Health a tem 27 is		Jacqueline B Albertson	Dtr	208	Coldbro	ok Ro	o a d Tim	onium	Mary	l and	2109	3
2	altimore,	Se do		20a. Method of Disposition XX Burial 2 □ Cremation 3 □ Removal from St		Place of Dispo cemetery, crea	sition (Name of matory or other	of r place)		Date		ocation - C		
٤ .	Ĕ	. Pag tment tant: I		'4☐Donation 5 ☐ Other (Specify)	Dr		dge Cem			2/04				Maryland
Loven	Baj	permit. Page Department (Important: If any injury or		21 Signature of Funeral Beryice Licensee	kis		2. Name and A		6500 Yor	k Road B	altim			nd 21212
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d.	ta	ilclan: Th certificate rector, pag	a)	25. Was case referred to medical				26.	Place of Deat			0 1 1] Yes	2 No
	ίV	S 0 0	To B	examiner? 1 Yes 2 No Hospital: 1 In	patient 2	ER/Outpatie	nt 3 DOA	Other: 4	☐ Nursing Ho	ome 5 Res	sidence	6 Other	(Specify	, Hospize
5	n 0	ing Pt		27. Manner of Death 1 ☐Natural 5 ☐ Pending 28a. Date of (Month)	Injury , Day Year)	28b. Time o Injury		Injury at Work?	0.50	28d. Describe	how inju	iry occurred	t	
-01	Division	ttendi death. stor: A	cati	2 Accident investigation 3 Suicide 6 Could not be	of Injury - At h	ome farm st	M reet, factory, of	1 Yes	2 🗆 NO	28f. Location	(Street a	nd Number	or Rura	l Route Number,
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3		To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral	edical C	29a. Certifier (Check only one) 1 Certifying Physician: To the base one and manner.	sis of examina									
		To the within To the	Me	29b. Signature and title of certifier			29c. Li	icense nur	mber		29d. D.	ate signed (Month, I	Day, Year)
)	10.2		Ville D. m	lon	nen	120 -	143	1178		\sim	ov. l	5, 0	2004
/		18		30. Name and address of person who completed cause Willram D. McGo-	of death (Ite	m 23a) (Type,	Print) 30/ /	V. C	harle	s Ba	1/2	nare	1	Day, Year) Le o Y Lergland
L	7	St Regist	atė trar	31. Date filed (Month, Day, Year) 32. Re	gistrar's Sign	ature p	parke							

DHMH 17 Rev 1/2001

6:30 pm

State of Maryland / Department of Health and Mental Hygiene, Reg. No. Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Physician 04 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner antal Columbia Howard Touse If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Days Hours Min 1□M 2ØF 88 -760 Yrs. Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County I show ral', or items 23a or 28a-f show Exercitive must be notified at 1 ☐ Yes 2√ No Columbia Howard Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 5400 Vantage Point Road 21044 Completed by Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: Pages 1 and 2 should be filed within 72 hours after 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2X No Specify: Specify: white Baltimore, Maryland 21215-0036 3 XWidowed 4 □ Divorced "natural" 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry d other than "natur event, the Medical Cotlege (1-4or 5+) Elementary/Secondary (0-12) Health and Mental Hygiene. em 27 is marked other then 0 housewife own home 18. Mother's Name (First, Middle, Maiden Sumame) 17 Father's Name (First, Middle, Last) Harold Roberts Regina Ward 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 Department of Health ar Important: If item 27 is any injury or other tran 4506 Wicomico Avenue Beltsville, MD 20705 Roger Williams/son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removat from State 4 Donation 5 Other (Specify) 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street
Baltimore, MD 21201 21. Signature of Euneral Service Licensee Ronald S, Wade non Baltimore, MD complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate 23a. Part1. Enter the disease, or com shock, or heart failure. List only Interval Between Onset and Death one cause on each tine tmmediate Cause (Finat Due to for as a consequence of): **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events as a consequence of) Examiner The law requires that the death certificate be executed burial-transit and resulting in death) Last P.O. Box 68760, the attending physician > seale Physician/Medical use as the IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year ō in the past 12 months? 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No detached 9 Unknown 9 TUnknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records. Be Completed by page 2 should be 4 Unknown 3 Probably 1 ☐ Yes 2 ☐ No peeu 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No has 2 No 1 Yes 6 or Attending Physician: 26. Place of Death (Check only one, funeral director, 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: Certification: To 2 No 1 🗌 Inpatient 2 ER/Outpatient 3□ DОА 1 Tyes 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death After Division 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. within 24 hours after death.

To the Funeral Director: A completely filled in by the fi 2 Accident investigation Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21228 2+ Con Pille 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MOV 1 8 2004 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienes O.O.

		1	For State State Registrar	or Marylan	Cei	rtificate of L	eaith and M Death	entai mygien Reg. N		36557
	Dhuaiais		Decedent's Name (First, Middle, Last)			-		2. Date of Death Month D	ay Year	3. Time of Death
	Physicia /Medic	21	Leroy	Wei	SS	4h City Tourn or	Location of Death		6, 2004 c. County of Deeth	7:33 P M
	Examin	er	4a. Facility Name <i>(If not institution, giv</i> e s <i>tr</i> ee <i>t and</i> 192 Strohn Dr.	number)		Pasa			Anne Ar	
3	Funeral Director		5. Social Security Number 6. Sex 1 M M 2	7. Age (In yrs. 88	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth Month, Day, Yea JUTY 31, 1	9. Birth 916 Max	place (State or Foreign intra) ^yland
	and	-	Usuel Residence of Decedent 10a. State 10b. County	10c. Cit	ty, Town or Lo	ocation				10d. Inside City Limits
	Mary s-f sho	ţō	Maryland Anne Arundel		Pasa	idena				1 ☐ Yes 2 🛣 No
	or 28	Director	10e. Street and Number			10f. Zip Code	20	10g. 0	Cilizen of What Cou	intry?
	ns 23a	Funeral	193 Strohn Drive 11. Marital Status 12. Was	Decedent Ever in U	.S. 13.	Was Decedent of Hi If Yes, specify Cuba		ecity Yes or No-	USA 14. Race - Amer	
020	be lied within 72 hours after death with the Maryland Hygiene. Hygiene. 4 Hygiene. 4 do ther than "natural", or items 23a or 28a-f show svent. I'm Medical Examinat must be indiffed at	by	1 Never Married 2 Married 1 1	d Forces? /es 2 D No s, Give X or Dates:		If Yes, specify Cuba 1 ☐ Yes 2 🛣 No		Rican, etc.)	Black, White Specify: W	nite
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2	be filed tal Hyg d other svent.	BeC	17. Father's Name (First, Middle, Last)					(First, Middle, Maid		
yland		2	John 19a. Informant's Name/Relationship (Type, Print)	Weiss		ng Address (Street		Stina A Route Number, City		umpner
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e,	tam tam othe	i	20a. Method of Disposition 1X☐ Burial 2 ☐ Cremation 3 ☐ Removal i	20b. I	Place of Dispo cemetery, cre	osition (Name of matory or other place	θ)	Date 20c.	Location - City or 7	
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g	permit. Pag Department Important: sny injury o		21. Signature of Puneral Service Ucens	•	ĺ	3111 Mour	Sta Stain Road	allings Fu I Pasadena		
			23a. Pert1. Enter the disease, or complications shock, or heart failure. List only one cause	hat caused the dea on each line.	th. Do not en	ter the mode of dyin	g, such as cardiac	or respiratory arrest,	110 21122	Approximate Interval Between
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	/Medical Examiner		resulting in death)	e to (or as a consec	quence of):	(
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ion	ath. or: Afte	atio	2 Accident investigation	(Month, Day Year)	Injury		Yes 2 □No			
Division of	or Attending latter death. Director: After in by the funer	Certification:	3 Suicide 6 Could not be determined 28e.	Place of Injury - At I building, etc. (Spec	nome, farm, si rify)	treet, factory, office		28f. Location (Street City or Town, St		ral Route Number,
	To the Hospitet or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	a Ce	29a. Certifier Certifying Physicien:	To the best of my kr	nowledge, dea	th occurred at the tir	ne, date and place,	and due to the cause	(s) and manner as	stated.
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	10		30. Name and address of person who completed	t cause of death (Ite	em 23a) (Type	, Print)		(;)		17,2004
	Ψ		Mayer Godsal	22 Parished 5:	795	Hquaho	WIRd.	Glea Bo	vale, al	2/06/
	St Regist	ate rar	31. Date filed (Month, Day, Year)	32. Registrar's Sign	g de	parker				

			1 - State of M	aryland / Departm <i>Certific</i>	nent of Health and Notate of Death	lental Hygie		36558
	Physici	an	1. Decedent's Name (First, Middle, Last)		. (2) - 5.05	2. Date of Death Month	Day Year	3. Time of Death
	/Medic	cal	4a. Facility Name (If not institution, give street and number	1 45	WALTERS City, Town, or Location of Death	Nosember	15 5004	3:204
	Examin	ier	The three Halling In 10	front 1 16	City, Town, or Education of Death	(L.	4c. County of Death N/A	
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	Director		214-66-1120 1 ^{72 M 2□ F}	49 Yrs. Mor	nths Days Hours Min.	FEB. 15	,1955 MA	RYLAND
	and w		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Location	1		1/	0d. Inside City Limits
	Maryl	ţ	MD. BALTIMORE	MIDDLE	RTVER			1 ☐ Yes 2 XNo
	r 28a	Director	10e. Street and Number		f. Zîp Code	10g.	Citizen of What Coun	try?
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and	b d la b	Be	17. Father's Name (First, Middle, Last) GEORGE F. WALTERS, SR			e (First, Middle, Maid	len Sumame)	
5	should nd Mer marke	2	19a. Informant's Name/Relationship (Type, Print)		BETTY dress (Street and Number or Run	TREMOR al Route Number, Ci	tv or Town, State, Zip	Code)
M	d 2 th a 7 Is		GEORGE F. WALTERS, SR./					
e G	iges 1 and of Heeling 2 or other		20a. Method of Disposition 1 ☐ Burial 2 🎇 Cremation 3 ☐ Removal from State	20b. Place of Disposition	(Name of		. Location - City or To	
Ĕ	Pag ment ant: I ury o		' 4 ☐ Donation 5 ☐ Other (Specify)	BAYVIEW C	REMATORY 11/	18/04 BA	LTIMORE,	MARYLAND
Baltimore	permit. Depertr Imports any Inj once.		21. Signature of Funcional Service Licensee	LIL.	ne and Address of Facility LY & ZEILER	INC. FUN	ERAL HOMI	Ξ
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	į,		30. Name and address of person who completed cause of					
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DHMH 17 Rev 1/2001

ORIGINAL

			State of Maryland / Department of Health and N 1 - State Registrer Certificate of Death		giene 004	36559
	Physici	an	1. Decedent's Name (First, Middle, Last)	2. Date of Dea	Day Zoo	3. Time of Death
	/Medio Examin		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death	1404	4c. County of Dea	
			SAINT AGNES HEHOTHEARE BALTIMORE		N/A	
	Funeral Director		5. Social Security Number 6. Sex 1 M 2 F 7. Age (In yrs. last birthday) 7. Age (In yrs. last birthday) 7. Age (In yrs. last birthday) 8. Age (In yrs. last birthday) 9. Age (In yrs. last birthday) 15. Age (In yrs. last birthday) 15. Age (In yrs. last birthday) 16. Sex 15. Age (In yrs. last birthday) 17. Age (In yrs. last birthday) 18. Age (In yrs. last birthday) 19. Age (In yrs. l	8. Date of Birth (Month, Day		hplace (State or Foreign untry)
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	with th	Dire	10e. Street and Number 10f. Zip Code		10g. Citizen of What Co	ountry?
	leath ins 23	eral	2543 Lauretta Avenue 21223 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No-	14. Race - Ame	
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003	hours urel',	d by	3 ☐ Widowed 4 ☐ Divorced Year or Dates:		Di	ack
75	filed within 72 hours after death with the Maryland Hygiene. ther then "naturel", or Items 23a or 28a-f show ent, it a Medical Examination must be millied at	Completed by Funeral Director	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0·12) College (1-4or 5+) 16a. Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired)	ing	16b. Kind of Business	industry
212	e filed with al Hygiene. other than vent, II.v. N	Com	8 years Welder		MD Dryc	dock
and	l be filt ntal Hy ed oth	Be	17. Father's Name (First, Middle, Last) 18. Mother's Name			
الإلا	s 1 and 2 should be filed within 72 hours after death with the Marylan Hygiene. I Heath and Mental Hygiene. Item 27 is marked other than "naturel", or Items 23a or 28a-f show other traumatic event, If a Moulcal Examiner must be millied at	²	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Run		r, City or Town, State,	
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Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 s Depirtment of Health ar Important: If item 27 is any injury or other trau		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State	Date	20c. Location - City or	Town, State
謹	it. Parintmen rtant: njury		'4 □Donation 5 □Other (Specify) Gorn Son ForeSt 11/2. 21. Signature of Funeral Service Licensee / 22. Name and Address of Facility 14.			s, MD
Ba	Deptil Importantia		mark Itm/llor Han i mater Heis	ente A	ue. Balto.	
			23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on each line.			Approximate Interval Between
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30X	leath certifica attending pl	lan/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy		23d. Date of de	ivery Day Year
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J &	v require been sig should b	ted	HYPERTENSION, PEPTIC INCER DISEASE, history of	1 🗆 Y	es 2 □ No 3 □ Pr	
Se C	e law has b	Completed	RENALCARCINONIA	24a. Was a autops perfor	an 24b. Were au prior to med? death?	topsy findings available completion of cause of
) (Ital		0	25. Was case referred to medical 26. Place of Deat	1 ☐ Yes	No 1 Yes	2 No
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R161	Attendi r death. ector: A	Certification:	3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office	28f. Location (S. City or Town	treet and Number or Ru	ıral Route Number,
9 6	Hospital or Attending 44 hours after death. Funerel Director: After tely filled in by the fune	Cert	4 ☐ Homicide determined building, etc. (Specify)	City of Town	n, Siale)	
5		Medical	29a. Certifier Check only (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and manner stated.	and due to the c red at the time, d	ause(s) and manner as late and place, and due	stated. to the cause(s)
	To the within 2 To the Comple	Me	29b. Signature and title of certifier 29c. License number	2	29d. Date signed (Mont	h, Day, Year)
	1		MARCIUS GANN MO ASZU385Z8-3221		NOV 16	2004
	4		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MARCUS GANN JR MD 900 CATON AVE BACTIMO	ef MO	21229	
	Sta	ate	31. Date filed (Month, Day, Year) 32. Registrar's Signature		100000	
	Regist	rar	NOV 1 8 2004 Secure & frank			

			Please '	Type or Print in I	Black Ind	elible Ink. Ensu	re All Copies	s Are Legible.	
			For State	State of Marylar		tment of Health a ificate of Death	and Mental Hy	2001.	36561
			Registrar 1. Decedent's Name (First, Middle, Las))	Certi	ilicale of Dealif	2. Date of D	Reg. No.C U U	3. Time of Death
	Physic		WILLIAM		MMER	MAN	Month NO V	Day Year 16 2004	
	/Medi Exami		4a. Facility Name (If not institution, give			4b. City, Town, or Location of		4c. County of Deal	10.00
			FRANKLIN SQUARE	HOSPITAL CEN	ITER	ROSEDALE		BALTIM	ORE
	Funeral Director		214-17-18 DE/	7. Age (In yrs.		If Under 1 Year If Under Months Days Hours	24 Hrs. 8. Date of Bi (Month, D	irth 9. Birth Co.	hplace (State or Foreign nuntry)
	/land iow		Usual Residence of Decedent 10a. State 10b. County	1	ty, Town or Loca			/	10d. Inside City Limits
	death with the Maryland ms 23a or 28a-f show If sust be redified at	ctor	MD BAL	Imore		Rosedale			1 Tes 2 No
	or 28	Dire	10e. Street and Number			10f. Zip Code		10g. Citizen of What Co	untry?
7	ath w	- La			CT.	2123		U·S.	<u>†) - </u>
WILL 142 5-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene important: if item 27 is marked other than "natural", or itams 23a or 28a-f show important: if item 27 is marked other than "natural", or itams 23a or 28a-f show any injury or other treumatic event, the Medical Evertimes and the rectified at 2000.	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 2 □ Widowed 4 □ Divorced	If Yes, Give	5. 1	as Decedent of Hispanic Ori es, specify Cuban, Mexicar Yes 22 No Specify:	gin? (Specify Yes or N n, Puerto Rican, etc.)	14. Race - Ame Black, Whit	
1-0-9	72 hou	Completed	15. Decedent's Ed (Specify only highest grad		16a. Decede	nt's Usual Occupation and of work done during mos	t of working	16b. Kind of Business/	Industry
	within 7 ene. than "c	npie	Elementary/Secondary (0-12)	College (1-4or 5+)	life. DC	NOT use retired)	t or working		5 0O
7 7	filed w Hygier other th	S	17. Father's Name (First, Middle, Last)	NIA		MAINTANCE	er's Name (First, Middle	Si Luer	CORP.
MAN	ntal Hed of	Be	Unknow?			D		- FONG	
\$ 2	should nd Men marke	To	19a. Informant's Name/Relationship (7	ype, Print)	19b. Mailing	Address (Street and Number	or or Rural Route Num		Zip Code)
京西	nd 2 stith ar		KATHY BURKE	•	5213	GLENTHOR	ne CT. T	Posalnie A	10 21237
ie,	s 1 au of Hea item		20a. Method of Disposition	20b.		ion (Name of tory or other place)	Date	20c. Location - City or	
ZIMMER imore, Mary	Pages nent of ant: If it ary or o		1 Surial 2 Cremation 3 U 4 Donation 5 Other (Specify	removal from State	RKWOOD	cem	11/19/04	Bs Ho. M	
ZiMMeRがAM Baltimore, Maryland 2121	permit. Departr Importe any inje		21. Signature of Funeral Service Licen	Ftoll.	22. I	Name and Address of Facility	STELLA F RD. DOLL		
	ME I		23a. Pary1. Enter the disease, or comp	lications that caused the dea	th. Do not enter	the mode of dying, such as			Approximate Interval Between
1	Priysician		shock, or heart failure. List only of Immediate Cause (Final disease or condition	a ASPIRATION	1 PHEL	IMONIA			Onset and Death
	/Medical		resulting in death)	Due to (or as a conse					
	Examiner		Sequentially list conditions,	b. ISCHEMIC		E			
	sit s	Examiner	it any, leading to limite diate cause. Enter Underlying Cause (Disease or injury	Clia to (or as a consa	quenna of):				
	be executed ician and burial-transit	хап	that initiated events resulting in death) Last	c. Due to (or as a consec	quence of):				
760,	eath certificate be execul attending physician and for use as the burial-tra			d					
687	tificati g phy as the	Physician/Medical							
Вох	th cer tendir r use	an//h	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregn 1 ☐ Live birth 2 ☐ Fet	ancy al death 3 □E	ctopic pregnancy		23d. Date of del Month	ivery Day Year
	e dea the at ned fo	sici	1 Yes 2 No	4☐Pregnant at time of 9☐ Unknown	death 5□0	Other (specify)		Month	Day 18a
P.0	The law requires that the death certificate be the has been signed by the attending physicial page 2 should be detached for use as the bur	Phy	Part II. Dther significant conditions of	ontributing to death but not re-	sulting in the und	eriving cause given in Part I	. 23e. Did	tobacco use contribute to	the cause of death?
ds,	signe signe	d by		•		, , , , , , , , , , , , , , , , , , , ,		Yes 2□No 3□Pr	obably 4 Dunknown
of Vital Records,	w requ	Completed by			- 1, 1,		24a. Wa	s an 24b. Were au	itopsy findings available
Be	The law	шс					auto perf	opsy prior to of death?	completion of cause of
ta		a	25. Was case referred to medical			26. Place	1 ☐ Yes of Death (Check only		2 140
>	Physician: this certific ral director,	To B	examiner?	Hospital: 1 Impatient 2	ER/Outpatient	3 DOA Other: 4 Nu	rsing Home 5 Res	sidence 6 □Other (Spec	cify)
0	ding Phys h. After this funeral di	on:	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?		how injury occurred	
<u>S</u>	Attending r death. ector: After by the fune	catl	2 Accident investigation			M 1 Yes 2			
Division	spital or Attene ours after deatl nere! Director: filled in by the	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At I building, etc. (Spec.	nome, farm, stree ify)	at, factory, office	28t. Location City or To	(Street and Number or Ru own, State)	rai Houte Number,
	To the Hospital or Attenwithin 24 hours after deatl To the Funeral Director:	edical Ce	29a. Certifier Check only one) CertifyIng Ph	ysician: To the best of my kn liner: On the basis of examin and manner stated.	owledge, death o ation and/or inve	occurred at the time, date an stigation, in my opinion, dea	d place, and due to the th occurred at the time	e cause(s) and manner as , date and place, and due	stated. to the cause(s)
	To the Hos within 24 h To the Fur completely	Med	29b. Signature and title of certifier			29c. License number		29d. Date signed (Monti	n, Day, Year)

State Registrar Dr. WASSIM EL-HITTI
31. Date filed (Month, Day, Year)
NOV 1 8 2004

9000 FRANKLIN SQUARE DRIVE, BALTIMORE, MD 21237 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

D006 1251

parks

HOVEMBER 16, 2004

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

ORIGINAL

32. Registrar's Signature

amend 5-22 per F.H. g837 11/18/04 KBH Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State	State of Mar		artment of I		Mental Hy	/giene ™g. ଲେ.ଠାଠା	0000			
			1. Decedent's Name (First, Middle, La	ast)		Timodio or	Dodin	2. Date of De		3. Time of Death			
	Physicia		AKSHARA	BODE		oct.	25 Day 2004 6:15]						
)	/Medic Examin		4a. Facility Name (If not institution, git Univ. of Mary	ve street and number) Land Medic	al Syst	4b. City, Town, o	r Location of De LMOTE	eath	4c. County of [Death			
	Funeral Director		,	Sex 7. Age (In yrs. last birthday) Yrs.	If Under 1 Year Months Days 23		8. Date of Bi	rth year) 9.	Birthplace (State or Foreign Country) MD			
	D		Usual Residence of Decedent 10a. State 10b. County	1	Oc. City, Town or Lo	position				10d. Inside City Limits			
	anyla shov	5			oc. City, Town of La	ocation				1 ☐ Yes 2 No			
	8a-f	ectc	MD Montgor	nery	Silver	Spring			10 000				
	with t	급	10e. Street and Number	4100		10f. Zip Code	,		10g. Citizen of Wha	it Country?			
	s 23	era	14109 Castle Blvd	12. Was Decedent Ev	erin II S 13	2090		(Specify Ves or N	USA	American Indian,			
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Importent: If Item 27 Is marked other than "netural", or Items 23e or 28e-f show any figury or other treumatic event, the Medical Exaction manable notified at ance.	by Funeral Director	11. Marital Status 1 ☑ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		1 ☐ Yes 2 ☐ No		(Specify Yes or Nierto Rican, etc.)	Black, \ Specify:	White, etc. Asian			
Š	2 hot	ted	15. Decedent's E		16a. Dece	dent's Usual Occu	oation		16b. Kind of Busin	ess/Industry			
21215-0036	d within 7. giene. er than "n	Completed	(Specify only highest gi	College (1-4or 5+)	life.	kind of work done DO NOT use retire	d) most or t	working	infa	nt			
Maryland	utd be file Mental Hy, irked othe	To Be C	17. Father's Name (First, Middle, Las Venu Bode	t)			1	Name (First, Middle tha Minu	mula				
Mary	12 sho h and h 7 Is ma treuma		19a. Informant's Name/Relationship Venu Bode (fath						oer, City or Town, Sta Spring, N				
	1 and Healt em 2 ther	Į.	20a. Method of Disposition		20b. Place of Dispo	sition (Name of		Date	20c. Location - Cit				
Baltimore,	Pages 1 tment of F tent: If Ite		1 ☑Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Spec										
Bal	Depar Depar Impor any in	ji i	1 Removal from State 1 Removal from State 1 Removal from State 1 Removal from State 1 Removal from State 1 Removal from State 1 Removal from Park 1 Removal from Park 1 Removal from Park 1 Removal from Park 1 Removal from Park 1 Removal from Park 1 Removal from Park 1 Removal from Park 1 Removal from Park 1 Removal from Park 1 Removal from Park 2 Removal from Park										
	Physician /Medical	8 4	23a. Part1. Enter the disease, or cor shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	y one cause on each line. Sepsis a	consequence of):	ter the mode of dyi	ng, such as card	diac or respiratory a	arre <i>s</i> t,	Approximate Interval Between Onset and Death			
	Examiner				Respira	tory Di	stress	Syndro	me				
Ċ	n =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury		consequence of):	/ 1				4			
8760,	death certificate be executed attending physician and of for use as the burial-transit	al Examiner	Cause (Disease or injury that initiated events resulting in death) Last	C.	e Premat	urity							
9	g physicate as the	ledical		d				-	-				
P.O. Box	the death certific / the attending p ched for use as i	Completed by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of 1 ☐Live birth 2 4 ☐ Pregnant at tii 9 ☐ Unknown	Fetal death 3	□Ectopic pregnand □ Other (specify)	у		23d. Date of Month	Day Year 2004			
	w requires that the di been signed by the should be detached	d by Ph	Part II. Other significant conditions	contributing to death but	not resulting in the u	inderlying cause gi	ven in Part I.		3.7	te to the cause of death? Probably 4 Unknown			
Records,	e lav has je 2	ompiete							opsy prior deat	e autopsy findings available r to completion of cause of th? Yes 2X No			
Vital	Iclan: Th certificate ector, pag	0	25. Was case referred to medical	T			26. Place of (1 ☐ Yes Death (Check only		165 245 140			
>		ToB	examiner? 1 ☐ Yes 2X No	Hospital: 1 1 Inpatient	nt 3□ DOA Ot	nan.		idence 6 Other (Specify)				
Division of	ding h. After fune		27. Manner of Death XX Natural 5 Pending 2 Accident investigate	28a. Date of Injury (Month, Day)		of 28c. Inju			how injury occurred				
Divis	pital or Atte burs after de lerel Directo filled in by th	Certification;	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine		y - At home, farm, st (Specify)	reet, factory, office			(Street and Number o own, State)	or Rural Route Number,			
	Hos Hos Fun Tely	Medical (29a. Certifying F (Check only one) 1 X Certifying F 2 Medical Ext	Physician: To the best of aminer: On the basis of e and manner state	xamination and/or in	th occurred at the to execution, in my	me, date and pla opinion, death or	ace, and due to the ccurred at the time	cause(s) and manne , date and place, and	or as stated. due to the cause(s)			
	within 2 To the comple	Σ	29b. Signature and fittle of certifier			29c. Licen P186			29d. Date signed (A NOV. 8,				
·f	X		30 Name and address of person who Madhavi Sange			- 0		re, Md	21201				
	Sta Regist		31. Date filed (Manth 128 2	004 32. Projetra	s Signature	sport	2/						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		For State Registrar	State of M	aryland	•	artment of tificate of				ene g. No. 2 (nnı.	3650
Physicia	ın	1. Decedent's Name (First, Middle, Last	NES L.	BOSW	ELL				2. Date of Death		Year 200	3. Time of Death
/Medic Examin		4a. Facility Name (If not institution, give Washington Ad	street and number)			4b. City, Town,	or Location of			4c. County		
Funeral Director		5. Social Security Number 6. Se 579-52-2157	x 7. Ag	je (In yrs. la:		If Under 1 Yea Months Days		Min.	8. Date of Birth (Month, Day, Jan 7,	Year)	9. Birthp	lace (State or Foreign Mand
Maryland f show	or	Usual Residence of Decedent 10a. State 10b. County DC No	ne	10c. City,	Town or Lo	cation hingtor	n				1	0d. Inside City Limits 1 Yes 2 □ No
with the Na or 28a-	Funeral Director	10e. Street and Number 803 Gallatin		N.E.		10f. Zip Code	. 7	,	10	g. Citizen of V		try?
Baltimore, Maryland 21213-0030 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show important: If item 27 is marked other than "natural", or items 23a or 28a-f show any intry openiter traumatic event, the Madical Examinar must be notified at once.	by Funera	11. Marital Status 1 □ Never Married 2 □ Married /3© Widowed 4 □ Divorced	12. Was Decedent Armed Forces? 1 Yes 201	Ever in U.S		Was Decedent of f Yes, specify Cu	Hispanic Ori ban, Mexicar	gin? (Spe n, Puerto	cify Yes or No- Rican, etc.)	14. Rac	e - Americ ck, White,	
Z15-UU36 thin 72 hours all e. an "natural", or Wedical Exam	Completed b	15. Decedent's Edi (Specify only highest grade	le completed)	ation (Give k		sedent's Usual Occupation re kind of work done during most of working DO NOT use retired			ng	6b. Kind of B	usiness/inc	
and Z1,	Be Con	12th Grade 17. Father's Name (First, Middle, Last) Benjamin	Jackson			Housewi	18. Mothe	ers Name	(First, Middle, M	faiden Suman	ome ne)	
Maryland of 2 should be file the and Mental Hy 27 is marked oth r traumatic even	To	19a. Informant's Name/Relationship (T					and Number	er or Rura	l Route Number,	City or Town,		Code) Ad 20740
Saltimore, sernit, Pages 1 ar appartment of Hea mportant: If item nny injury or othe		20a. Method of Disposition 1 Surial 2 Cremation 3 4 Donation 5 Other (Specify,	Removal from State	20b. Pla	ace of Dispo metery, crer	sition (Name of natory or other pl	ace)	D	ate	loc. Location -	City or To	
Danti permit. Departr importe any inju	(21. Signature of Funeral Service Idens	Anon	de		246 N.	wasn.	ιngτ	Home on St,	ROCK	20850 7111	o Md Approximate
Wedical (American and American and American) (American and American and Americans) (Americans) (Americ	dicai Examiner	23a. Part1. Enter the disease, or comp shock, or heart failure. List only to immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	//	a conseque	of):	Interry	As-	_	1			Interval Batween Onset and Death
.O. BOX 6 the death certifi y the attending I ached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant a 9 □ Unknown	2 Fetal	death 3	Ectopic pregnan Other (specify)	су				te of delive	ry Day Year
Jet hat	by	Part II. Other significant conditions co	ontributing to death	out not resul	lting in the u	nderlying cause g	iven in Part I			acco use cont s 2 □ No		ably 4 Unknown
I Rec The law ate has b	Completed								24a. Was ar autopsy perform 1 Ves 2	ed2-	prior to con death?	osy findings available inpletion of cause of
ision of Vital F utending Physician: Th death. ctor: Atter this certificate y the funeral director, pag	ation: To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Accident Pending investigation	Hospital: 1 ☐ Inpati 28a. Date of Inj (Month, Da	ury /	R/Outpatier 28b. Time o Injury	28c. Inj W	ther: 4 Nu	ırsing Hor	n (Check only one me 5 Reside 28d. Describe ho	nce 6 Oth		')
Division To the Hospital or Attending within 24 hours after cleath. To the Funeral Diractor: Afte completely filled in by the fune	Certification:	3 Suicide 6 Could not be 4 Homicide determined	building, e	tc. (Specify)		eet, factory, office			28f. Location (Str City or Town	, State)		
the Hosp in 24 hou the Fune apletely fil	ledical	(Check only 2 Medical Examone)	ysician: To the best liner: On the basis and manner s	of examination		vestigation, in my	opinion, dea		ed at the time, da	te and place,	and due to	the cause(s)
To To To To To To To To To To To To To T	Σ	29b. Signature and the of certifier	KK	<u></u>		45	203	,		d. Date signe		
,		30. Name and address of person who of Dr Stephe	n Smith	M.D,	, 760	0 Carro	oll a	ve,	Takoma	Park	, Md	
Sta Regist	ate rar	31. Date filed (Month, Day, Year)		rar's Signati	J J	Spark	2					

		1 - For State Registrar	State of Man		artment of H rtificate of L			ene 2004	36564	
Physici /Medi			land	Boggs		Jr.	2. Date of Death Month Novembe			
Examir	ner	4a. Facility Name (If not institution, give s 316 Broadway Stree			4b. City, Town, or Cumberla	Location of Death and		4c. County of Dea Allegany	th	
Funeral Director		5. Social Security Number 6. Sex 278-28-4509	7. Age (// 75	n yrs. last birthday) Yrs.	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.		8. Date of Birth (Month, Day,) May 29,	1929 9. Bir	thplace (State or Foreign ountry)	
Maryland -f show	tor	Usual Residence of Decedent 10a. State MD 10b. County Allegany		Oc. City, Town or Lo	ocation Derland				10d. Inside City Limits 1√ Yes 2 □ No	
with the la or 28a Lbe noti	Direc	10e. Street and Number 316 Broadway Street	et		10f. Zip Code	21502	100	g. Citizen of What Co	ountry?	
IIIG X IX 13-0030 be filed within 72 hours after death with the Maryland lat Hygiene. d other then "natural", or items 23s or 28s-1 show svent, I're Market Exalvither number or positive at the market of the confiled at	by Funeral Director		12. Was Decedent Eve Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		Was Decedent of Hispanic Origin? (Specify Yes or If Yes, specify Cuban, Mexican, Puerto Rican, etc. 1 Yes 2 No Specify:			No- 14. Race - American Indian, Black, White, etc. Specify: White		
A I A I S-0050 ad within 72 hours aft giene. er then "natural", or ure Mascal Exam	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)		(Give	dent's Usual Occupa kind of work done o DO NOT use retired, Y guard	lurina most of worl	king	Bb. Kind of Business	/Industry	
iryiand & thould be filed v id Mental Hygie marked other matic svent, II	To Be C	17. Father's Name (First, Middle, Last) Orland Moody Bo	ggs				o (First, Middle, Ma Cottrell Bog	,		
Maryland of 2 should be file the and Mental Hy 27 Is marked oth traumatic svent	 -	19a. Informant's Name/Relationship (Ty) Patty Boggs	_{ре, Print)} wife		ng Address (Street a		ral Route Number, C Cumbe	City or Town, State, .	Zip Code) D 21502	
Baltimore, Maryiar permit. Pages 1 and 2 should be Department of Health and Menta Importent: If them 27 ts marked any injury or other traumatic se once.		20a. Method of Disposition 1 🖾 Burial 2 □ Cremation 3 □ R 1 □ Donation 5 □ Other (Specify)	emoval from State	20b. Place of Dispo cemetery, crei Restlawn Me	esition (Name of matory or other place emorial Gard	dens	Date 20	oc. Location - City or _aVale	Town, State	
Dalt permit. Departm Importe any inju		21. Signature of Funeral Service License	I Dan	W 22	Name and Address Scarpelli			nd. MD 2150	2	
by 700, A content of the principle of the purial-transit is the burial-transit of the purial-transit of the pu	ai Examiner	23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Fint ar Undertying Cause (Disease or injury that initiated events resulting in death) Last		onsequence of):	er the mode of dying		or respiratory arres	it,	Approximate Interval Between Onset and Death	
he death certiff the attending	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	3c. If yes, outcome of p 1 ∐ Live birth 2 ⊑ 4 □ Pregnant at tim 9 □ Unknown	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of del Month	ivery Day Year	
- E 5 8	þ	Part II. Other significant conditions cor	stributing to death but n	ot resulting in the u	nderlying cause give	en in Part I.		. /	the cause of death?	
The The ate h	Completed						24a. Was an autopsy performa	prior to	utopsy findings available completion of cause of	
OI VILLAI Phyeicien: T this certificate ral director, pa	o Be	25. Was case referred to medical examiner?	ospital:	2 ☐ ER/Outpatier	nt 3 DOA Othe		th <i>(Check only one)</i> ome 5⊻ Residen	ce 6 □Other (Spe	cify)	
	tion; T	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Yo	ear) 28b. Time o	f 28c. Injury Work		28d. Describe how			
- F # F C	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury building, etc. (- At home, farm, str Specify)	eet, factory, office		28f. Location (Stree City or Town,	et and Number or Ru State)	ural Route Number,	
To the Hospitel of within 24 hours af To the Funerel D completely filled is	Medical Co		sician: To the best of more: On the basis of ex and manner stated	amination and/or in						
To the within : To the comple	Me	29b. Signature and title of certifier)		29c. License	number	290	d. Date signed (Mont	h. Day, Year)	
		Van VI			D091	57	N	lovember 1	3, 2004	
St. Regist	ate rar	30. Name and address of person who con Paul Snow, M.D., 31. Date filed (Month, Day, Year) NOV 1 8 2004		d Examine		3rd St;	Cumberla	nd, MD 2	1502	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiers | | | | 36565 For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Month **Physician** 19:00 M Bean 09 Carolyn 04 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Allegany Cumberland Hospital Hear pacred If Under 1 Year If Under 24 Hrs. Months Days Hours Min. Dec 28, 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex **Funeral** Months 1 ☐ M 2 ☐ F Wid Yrs. 220-52-7500 Director 56 Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a State 10d. Inside City Limits 10h County 28a-f ahow the Medical Examiner must be notified at Allegany MD Cumberland 1√ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō 21502 1312 Lexington Avenue USA Itеms 23a Funeral 72 hours after death 12, Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 5 1 ☐ Yes 2 No Specify Specify: white ģ 3 Widowed 4 Divorced "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 1.2 should be fited within 7 h and Mental Hygiene.
7 la marked other than "r Elementary/Secondary (0-12) College (1-4or 5+) homemaker own home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ray R. Jones Linnie Juanita Phillips Jones 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 st Department of Health and Importent: If item 27 I arn any injury or other traum James Bean husband 1312 Lexington Avenue Cumberland MD 21502 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, Stale 1 Xeurial 2 Cremation 3 Removal from State 11/12/2004 Cumberland Sunset Memorial Park MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Scarpelli Funeral Home, PA 21. Signature of Funeral Service Licensee once. 108 Virginia Avenue: Cumberland, MD 21502 23a. Part1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) · METASTATIC NONSMALL CELL CARCINOMAD **Physician** 2002 /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner the burial-transit certificate be exec Due to (or as a consequence of): 68760, attending physician Physician/Medicai as Box (IF FEMALE esn 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No for Month Year 4☐Pregnant at time of death 5 Other (specify) P.O. the detached 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, þ 3 ☐ Probably 4 ☐ Unknown 1 Yes 2 No Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2/ No 1 Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 1 Mnpatient 3 DOA 2 ER/Outpatient this funeral 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred Certification: After Division Attending 5 Pending investigation 1 Natural death. 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 Could not be determined 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) or A after 4 Homicide To the Hospital within 24 hours at To the Funerel D Hospital c 29a. Certifier 1/ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2006 D 233 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) #102, Cumberland, MD 21502 ZAMAN 625 WAMAR

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

2004

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32. Registrar's Signature

KRISTI	N BROWN	V	for Unpend Item 2	23a&12†e p(Marylages 3-P	qparty Certifi	<u>ըeըե</u> օքե	aealth and Death	Mental H	from (004	36566
			Decedent's Name (First, Middle, L.	ast)					2. Date of D			3. Time of Death
	Physici /Medio		KRISTIN SANTINA	BROWN					Month NOV	3, 2	2004	2129 P M
	Examir		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death								ounty of Death	
0			PRINCE GEORGES				CHEVE				RINCE G	EORGES
.0	Funeral		5. Social Security Number 212 13 4883 6. Sex 1 M A Months 212 13 4883 7. Age (In yrs. last birthday) 30 Yrs. 7. Age (In yrs. last birthday) Months Days Hours Min.							irth Day, Year)		place (State or Foreign intry)
3	Director		Usual Residence of Decedent		30				MAY 1	0, 197	4 WAS	HINGTON, DC
	death with the Maryland ma 23a or 28a-f show froughte notified at		10a. State 10b. County		10c. City, Town	or Location	n					10d. Inside City Limits
	the Marylan 28a-f show	Director	MARYLAND PRINCE	GEORGES	UPPPER	MARI	BORO					XXYes 2□No
	or 28	Dire	10e. Street and Number			1	of. Zip Code			10g. Citizer	of What Cou	intry?
	ath w		14200 FARNSWORTH					20772			ITED S'	
	ter de Item	Funeral	11. Marital Status	Armed For		13. Was If Yes	Decedent of H , specify Cuba	Hispanic Origin? (an, Mexican, Pue	Specify Yes or N nto Rican, etc.)	lo- 14.	Race - Ameri Black, White,	
36	irs aft	by F	1 ☐ Never Married ※※ Married 3 ☐ Widowed 4 ☐ Divorced	If yes Give 1 Yes VV No. Specify:							Specify: BLACK	
Maryland 21215-0036	2 should be filed within 72 hours after death with the Maryla, and Mental Hygiene. Is marked other than "natural", or tlema 23a or 28a-f show armatic event, the Modical Examination and the modified at		15. Decedent's E	ducation	16a. I	Decedent'	Usual Occup	ation		16b. Kind	of Business/In	ndustry
218	thin 7	Completed	(Specify only highest g. Elementary/Secondary (0-12)	College (1-		life. DO N	of work done OT use retired	during most of w d)	orking			
7	filed wil Hygien thar th	Con		4 YR	,		MANA	GER			PRIVATI	E
pu	be fill stal H d oth	Be	17. Father's Name (First, Middle, Las	t)				18. Mother's Na	ame (First, Middl	e, Maiden Su	mame)	
<u></u>	should and Men s marka umaric	2	MATHIEL T. COVINGTON SANDRA SIMPKINS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)									
Ma	d 2 st th and 7 ts in traum		19a. Informant's Name/Relationship									
	es 1 and 2 should b of Health and Ment f itam 27 is markad r other traumatic e		SANDRA SIMPKINS 20a. Method of Disposition	/ MOTHER	20b. Place of I			RTH LN.	#103	,	MARLBOI ion - City or To	RO, MD 2077
JO I	ages ant of t: If it		1XXBurial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Spec		State cemetery	, crematoi	y or other plac	· 1			-	
Baltimore,	permit. Pages Department of Important: If i any injury or one		21. Signature of Funeral Service Lice		HARMON			PARK 11			DOVER,	MD
ñ	permit. Departr Imports any inj		J. T. V	Vous	el	MARS 4308	HALL'S SUITL	ss of Facility FUNERAI AND ROAI	L HOME O	F MARY	LAND,IN	NC .
			23a. Part1. Enter the disease, or cor shock, or heart failure. List only	nplications that ca	used the death. Do no						20740	Approximate Interval Between
	Priysician :		Immediate Cause (Final disease or condition		ications o	f Svs	stemic	Larous Er	rvthemat	nene(S	LF)	Onset and Death
	/Medical		resulting in death)		or as a consequence of		-	Dupus L	' J Circuid C	d)carco	шу	
	Examiner	_	Sequentially list conditions,	b								
	ed isit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):									
	xecut and N-tran	хап										
8760,	icate be executed physician and the burial-transit											
		edicai		_ d.								
Вох	eath certifi attending I for use as	N/M	JF FEMALE: 23b. Was decedent pregnant		ome of pregnancy					23d	Date of delive	ery
Δ.	death e atte	icia	in the past 12 months? 1 X Yes 2 ☐ No	4∐Pregna	rth 2 Fetal death ant at time of death		pic pregnancy er (s <i>pecify)</i>				Month	Day Year
P.O.	at the de by the a tached	Physician/M	9 Unknown	9□ Unknov							(2	24 04
Ś	es that igned to be det	by F	Part II. Other significant conditions				he cause of death?					
ord	w requir been si should	ted							1 🗆	Yes 2.20N	o 3 Prob	pably 4 □Unknown
ec	e faw has b	Completed							24a. Was	s an 2	4b. Were auto	ppsy findings available mpletion of cause of
Division of Vital Records,									perf 1 X Yes	ormea?	death?	2 No
\ <u>\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\</u>	sician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	Hospital:			T DOA Oth		ath (Check only			
jo d	Phys rthis raldi	To	1 X Yes 2 No 27. Manner of Death	1 ☐ In 28a. Date of	patient ZXXER/Outp		DOA 28c. Injun	4 Nursing	Home 5 ☐ Res 28d. Describe			y)
no	ding F th: : After s funer	tion	Natural 5 Pending 2 Accident investigation	(Month	i, <i>Day Year)</i> Inj		Worl	k? Yes 2 □ No	200. 2000.100	now whaty or	2001100	
visi	Attar or dea actor by the	ifica	3 Suicide 6 Could not l	200. Flace (of Injury - At home, farr	n, street, f	actory, office		28f. Location	Street and N	umber or Rura	al Route Number,
ا ا	spital or Attand	Certification:	4 Homicide	bullang	g, etc. (Specify)				City or 10	wn, State)		
	8 년 년 년 19 년 년 년 년 년 년 년 년 년 년 년 년 년 년 년 년 년 년 년	edical	29a. Certifier (Check only one)	hysician: To the bas miner: On the bas and manne	pest of my knowledge, sis of examination and/ er stated.	death occ or investig	irred at the tin ation, in my o	ne, date and plac pinion, death occ	e, and due to the urred at the time,	cause(s) and date and pla	manner as st ce, and due to	lated. the cause(s)
	To the within 2 To tha comple	Ň	29b. Signature and title of certifier		4.0		29c. License				gned (Month, I	
			Carnill	los	Al.		U.C	.M.E		NOV.	4, 200)4
			30. Name and address of person who	completed cause								
		•	31. Date filed (Month, Day, Year)	32 Re	gistrar's Signature	ann S	treet,	Baltimo	ore, Mar	yland 2	21201	
	Sta Registr		NOV 1 8 20	.//	eners by		boards					

		ŀ	State of Maryland / Department of Health and Mental Hygien 2004 36567 Certificate of Death Reg. No. 36567
			1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death
и	Physici		CONSTANCE BRAXTON DOTOLOGY 12004 1202M
	/Medic Examin		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death
			MONTHWEST HESPITAL CENTER RANDAILS TOWN BACTMONE
	Funeral Director		5. Social Security Number 6. Sex 1 M 200F 7. Age (In yrs. last birthday) 1 M 200F 7. Age (In yrs. last birthday) 1 Months Days Hours Min. 4 - 4 - 3 7 9. Birthplace (State or Foreign Country) 9. Birthplace (State or Foreign Country) 1 M 200F 1 M 2
	put *		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits
	Maryla f sho	ō	0 1 7 2 1 7 No
	r 28a	Director	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?
	th with 23a o		#8-DINELEA COURT 21208 USA
	ems ems	Funerai	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc.
36	72 hours after death with the Maryland natural', or Items 23a or 28a-f show disal Examinar must be maiffied at	by Fu	1 Never Married 2 Married 1 Yes 2 No If Yes, Give 1 Yes Widowed 4 Provorced Year or Dates:
21215-0036	in 72 hours "natural", solical Ext	ted	15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry
215	c * 39	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) (Give kind of work done during most of working life. DO NOT use retired)
12	be filed withintal Hygiene. Ind other than avant, the M		12 5+ DISTRICT MANAGER STATE OF IVID
Maryland	ould be fi Mental H arked ot atic avar) Be	17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame)
ary	d 2 should th and Men 7 is marke traumatic	은	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
	d 2 th a 7 is		PATRIA BRAXTON DAIGHTER #8 PINEED COURT PIKESVILLE MA 21208 20a-Method of Disposition 20b. Place of Disposition (Name of Disposition) Date 20c. Location - City or Town, State
Baltimore,	of of		1 Surial 2 (Vernation 3 Removal from State
ij	permit. Pages Department of I Important: If its any injury or o		"4 Donation 5 Other (Specify) ZION UM CHUACH CEM! 116/04 SHARPTOWN NID
Bal	permil Depar Impor any in		21. Signature HF weat Service Licensee 22. Name and Address of Facility BENNIE SMITH FIH
			23a. Part 1. Enter the disease for complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate
	Physician		shock, or heart allure. List only one cause on each line. Immediate Cause (Final disease or condition) Can FMAD VMCC (AT ACC DENT
	/Medical		disease or condition resulting in death) a. CENERALO VITS Cell As. ARC DENT Due to (or as a consequence of):
996	Examiner	<u></u>	Sequentially list conditions, b. ———————————————————————————————————
	ted nsit	nine	Sequentially list conditions, if any, leading to immediate cause. Line Underlying Cause (Disease or injury
Ć.	execu in and ial-tra	Examiner	that initiated events c. resulting in death) Last Due to (or as a consequence of):
8760,	icate be executed physician and s the burial-transit	icai	d.
9	entifica sing ph e as t	Med	IF FEMALE:
Вох	eath certific attending p for use as t	cian/	23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months? in the past 12 mo
0	the de by the tached	Physician/Medical	1 Yes 2 No 9 Unknown 9 Unknown
s, P	res that igned b		Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death?
ord	w require been sti should b	ted	ENDSTAGE RENAL DISEASE, ANEMIA 1 Yes 20 No 3 Probably 4 Unknown
Record	e la has	Completed by	ANAS X2 Cot COLD my OC AND AL (NATIVE ELS) 24a. Was an autopsy findings available prior to completion of cause of death? 24b. Were autopsy findings available prior to completion of cause of death?
Vital		e Co	1 ☐ Yes 2 ☑ No 1 ☐ Yes 2 ☑ No
N N	Physician: this certific ral director,	OB	25. Place of Death (Check only one) examiner? 1 Yes 2 No Hospital: 1 Propagation 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)
n of	ng Ph Iter th	T :uc	27. Manner of Death 1 Patural 5 Pending 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Work?
Sio	tandlr eath. tor: Al	catio	2 Accident investigation M 1 Yes 2 No
Division	il or Attanding Pafter death. Director: After t	Certification:	4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
_	e Hospital 24 hours a a Funeral l letely filled		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
	To the Hospital or Attanding within 24 hours after death. To tha Funeral Director: After completely filled in by the funer	edical	(Check only 2 Medical Examines: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
	To T To 1	Σ	29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year)
•			20 Name and defines of access who completed access the completed access to death (flow case) To a District Construction of the completed access to the
			30. Name and address of person who completed cause of death (Item 23a) (Type, Print) OKLANDO B. COMANAN, ND RANDA((Ston)) 13. Date filed (Month, Day, Year) NOV 0 3 2004 32. Registrar's Signature Apouls
	Sta		31. Date filed (Month, Day, Year) ALOV 0.2 2004 32. Registrar's Signature Alove 1.2 Around 1.2 A
	Regist	rar	NOV 0 3 2004 Service & Apails

			1 - State Ragistrar	of Maryland /	Department of H Certificate of L	ealth and M D <i>eath</i>	ental Hygier Reg. 1	2004	36568
	Physici /Medic		1. Decedent's Name (First, Middle, Last) DAN N I E		BAKER			Day Year 31,2004	3. Time of Death
l	Examin Funeral Director		4a. Facility Name (If not institution, give street and THE TOHNS HOPKI 5. Social Security Number 5.77-40-0377 Usual Residence of Decedent	VS HOSPIT	AL BALTI	Location of Death MORE CI If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Yea May 21, 1	4c. County of Death 9. Birth, Cou 928 Rale	
	Maryland -f show fled at	tor	10a. State 10b. County Maryland Prince George	,	m or Location Hills				10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	3a or 28a	i Director	10e. Street and Number 4306 Delmar Ave.		10f. Zip Code 20748			Citizen of What Country?	
320	permit Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, I'le Modical Examination and Londined at Once.	by Funeral	11. Marital Status 1 Never Married 2 Married 1 Never Married 2 Married 1 Hyes 3 Widowed 4 Divorced	spanic Origin? (Spe n, Mexican, Puerto f Specify:		14. Race - American Indian, Black, White, etc. Specify: Black			
1215-0036	within 72 hou ene. than "natura he Mudical E	Completed	15. Decedent's Education (Specify only highest grade comple Elementary/Secondary (0-12) Colle 12th	ted) ge (1-4or 5+)	a. Decedent's Usual Occupa (Give kind of work done of life. DO NOT use retired) deral Employ	luring most of workir)	g	Kind of Business/Industry	
yland z	12 should be filed within 7 h and Mental Hygiene. 7 is marked other than " traumatic event, Ite Med	To Be Co	17. Father's Name (First, Middle, Last) Daniel Royster	re	derai Employ		(First, Middle, Maide	overnment en Sumame)	
Mary	nd 2 shoulth and M 27 is marl r traumati	-	19a. Informant's Name/Relationship (Type, Print, Harry Baker / Husba		b. Mailing Address (Street a				
saitimore,	Pages 1 and nent of Heamint: If item		20a. Method of Disposition 1	rom State 20b. Place comete	of Disposition (Name of ery, crematory or other place ope Cem.	ө) 11-6-	ate 20c.	Location - City or To	
Dail	permit Depara Import any in		21. Signature of Funeral Service Licensee	~>	22 Name and Addres Alexander 5538 Marlb	oro Pike	<u>Forestvil</u>	mes 1e,Md. 20)747
	Physician /Medical	:		on each line.	C SMALL			UCER	Approximate Interval Between Onset and Death 2 YEARS
8/60,	cate be executed by physician and burial-transit contact the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Dur. c. Dur. d.	- 5	5 DAYS				
O. BOX 6	death certifi e attending id for use as	Physician/Me	in the past 12 months?	s, outcome of pregnancy ive birth 2 □ Fetal death regnant at time of death Inknown	h 3 Ectopic pregnancy 5 Other (specify)			23d. Date of delive Month	ery Day Year
ras, r.	requires that the een signed by th nould be detache	δ	Part II. Other significant conditions contributing	to death but not resulting	in the underlying cause give	en in Part I.	23e. Did tobacco	o use contribute to the	he cause of death?
аі жесог	The larate has	Completed					24a. Was an autopsy performed?		opsy findings available impletion of cause of
VII	Physician: r this certific ral director,	To Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital:	1 ☑ Inpatient 2 🗀 ER/O	outpatient 3 DOA	26. Place of Death or: 4 ☐ Nursing Hom	(Check only one) ie 5 ☐ Residence	6 ☐Other (Specif	/v)
DIVISION OF	ding h. After fune	Certification;	27. Manner of Death 1 Natural 2 Accident investigation 3 Suiside 6 Could not be	(? Yes 2 □ No	8d. Describe how in				
2	To the Hospital or Attenwithin 24 hours after deat To the Funeral Diractor: completely filled in by the		4 Homicide determined 288.	Place of Injury - At home, fouilding, etc. (Specify)			8f. Location (Street and City or Town, Sta	1(e)	
	To the Hospital or within 24 hours af To the Funeral D completely filled in	Medical	29a. Certifier (Check only one) 1 ☑ Certifying Physician: To the control of the control on th	he basis of examination a manner stated.	nd/or investigation, in my op	pinion, death occurre	d at the time, date a	nd place, and due to	tated, the cause(s)
	To t To t	Σ	29b. Signature and title of certifier	14	29c. License			Date signed (Month,	
)	5)		Menbere Bahru, 1 30. Name and address of person who completed	redical Doc cause of death (Item 23a)	tor fl7			TOBER 31	
	Sta Regist		30. Name and address of person who complèted MENBELE BAHRU, JOHN 31. Date filed (Month, Day, Year) NOV 0 4 2004	P. Registrar's Signature	frest HL160	OO JUCKIH L	UULTE, DA	LILMORE, MA	INTLAND 2/287

			1 - For State Registrar	State of Ma	aryland	d / Depa <i>Cei</i>	artment of I tificate of	Health ai <i>Death</i>	nd Mental H	lygien Reg. N		365	569	
	Physici /Medio		1. Decedent's Name (First, Middle, Last) Esther S. Blu	ndon					2. Date of Month Novemb		ay 2004	3. Time of 1 6:30	Death P M	
	Examir		4a. Facility Name (If not institution, give so Wilson Health Car				4b. City, Town, Gaither	sburg			c. County of Deat Montgome			
	Funeral Director		5. Social Security Number 6. Sex 578-09-4599	7. Ag	9 (In yrs. la	ast birthday) Yrs.	If Under 1 Year Months Days		Min. 8. Date of Month 1	Birth Day, Year 3, 19	1 60	nplace (State or untry) ington		
	Maryland a-f show	tor	10a. State 10b. County Md. Montgomery	cation burg					10d. Inside Cit	-				
	with the	Director	10e. Street and Number	#c11			10f. Zip Code	077			itizen of What Co	•		
9036	permil. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Importent: If Item 27 is marked other than "natural", or Items 23e or 28e-1 show any injury or other treumatic event, the Medical Examinar must be notified at once.	d by Funeral	403 Russell Ave. ii 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent Armed Forces? 1 Yes 2 1 If Yes, Give Year or Dates:					n? (Specify Yes or Puerto Rican, etc.)		14. Race - Ame Black, White Specify: W	rican Indian,		
21215-0036	d within 72 h glene. or than "natu	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12) 12	(Give life. L	lent's Usual Occu kind of work done DO NOT use retire maker	pation during most o	of working		Kind of Business/ Wn Home	ndustry				
Maryland	ould be filed Mental Hyg arked othe	To Be C	17. Father's Name (First, Middle, Last) Howard Stein					Sadi	s Name (First, Midde e Sanders	on				
Mar	id 2 shi Ith and 27 is m freum		19a. Informant's Name/Relationship (Type Helen Pearson (Nie	. *					or Rural Route Num #101 Roc					
altimore,	Pages 1 are of Hea ont: If Item 2		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Re '4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	C6	ace of Dispo	sition (Name of natory or other pla	(ce) No	Date DV. 5,	20c. L	ocation - City or	Town, State		
Baltii	permit. P Departm Importer any inju		21. Signature of Funeral Service License	ay			. Name and Addr O East D	ess of Facility		neral	l Home		77	
	Medical Examiner superior is the buriat-transit	Examiner	23a. Part1. Enter the disease, or complic shock, or heart failure. List only one immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Diverti Due to (or as	ne. Culit a consequ a consequ	ence of):	er the mode of dy	ng, such as ca	ardiac or respiratory	/ arrest,		Approximate Interval Betwonset and D I Week	veen leath	
P.O. Box 68760,	The law requires that the death certificate be ate has been signed by the attending physicionage 2 should be detached for use as the bu	Physician/Medical	d. IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 N No 9 ☐ Unknown Part II. Other significant conditions continued to the significant conditions conditions conditions conditions conditions conditions conditions conditio	ic. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 ☐ Fetal time of de	death 3 ath 5	Ectopic pregnanc Other (specify)		23a Di	- I tobacco	23d. Date of delined Month	Day Ye	ear	
ords,	w requires t been signe should be o	sted by	Conjestive Heart			and at the di		- Taren		Yes 2		bably 4 Ur		
al Rec	sicien: The law certificate has b irector, page 2 s	Completed							pe 1 ☐ Yes	topsy rformed? 2X No	prior to c death?	opsy findings at ompletion of car 2 \(\sum \text{No} \)	vailable use of	
Division of Vital Records,	Phy this ald	on; To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 🏋 No 27. Manner of Death 1 🛣 Natural 5 ☐ Pending	ospital: 1	y	ER/Outpatien 28b. Time of Injury	28c. Inju	ner: 4 📉 Nurs	f Death (Check only ing Home 5 ☐ Re 28d. Describ	sidence		ify)		
Divisio	or Atten ifter deat Sirector: in by the	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injubul	Jry - At hor	me, farm, stre	Work? M 1 Yes 2 No reet, factory, office 28f. Location				tion (Street and Number or Rural Route Number, or Town, State)			
	To the Hospitel within 24 hours a To the Funeral I completely filled	edical C	29a. Certifier (Check only one) 1 Certifying Physical Control one) 2 ☐ Medical Examin	ician: To the best of er: On the basis of and manner sta	examinati	vledge, death ion and/or inv	occurred at the ti restigation, in my	me, date and opinion, death	place, and due to th occurred at the tim	e cause(s e, date an	and manner as d place, and due	stated. to the cause(s)		
	To the within To the comp	Me	29b. Signature and title of certifier	Wilm	ch		29c. Licen:	i 9 L 9	4		ate signed (Month		,4	
)		30. Name and address of person who cor Dr. John R. Melnick			23a) (Type, 1 1sse11			/ sburg, Md			,	-1	
	Sta Registr		31. Date-tiled (Month, Day, Year)	32. Registra			Spork							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For Stete Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Bannina sheila October 2004 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Kockvill greater Washington Montgonery MD Hebrew Home ot 7. Age (In yrs. last birtinday) If Under 24 Hrs 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) **Funeral** Days Months Hours 1 □ M 076-26-1850 Director 1932 NEW YORK Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10h. County 10a State or 28a-f show traumatic event, the Medical Examiner must be notified at MONTGOMERY ROCKVILLE 1 X Yes 2 □ No MARYLAND Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a 20852 6121 MONTROSE ROAD S. Α. Completed by Funeral Pages 1 and 2 should be filed within 72 hours after death and of Heatth and Mental Hygiene. Int: If item 27 Is marked other than "nature!, or items 23. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married WHITE Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: If Yes, Give Year or Dates: 3 XWidowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 12 YEARS 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be MARJORIE STERN SAMUEL SIMON 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6329 WINDERMERE CIRCLE, N. BETHESDA, MARYLAND 20852 CARIN Y. COOPER - DAUGHTER item 27 I 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of H
Importent: If ite
any injury or otl
once. 1 Burial 2 □ Cremation 3 □ Removal from State GARDEN OF REMEMBRANCE 11/3/2004 CLARKSBURG, MARYLAND ¹ 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility
EDWARD SAGEL FUNERAL DIRECTION,
1091 ROCKVILLE PIKE, ROCKVILLE, 21. Signature of Funeral Service Donald MARYLAND 20852 23a. Part 1. Enter the disease, or complications that caused the stath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate
Interval Between
Onset and Death
2 munthS Immediate Cause (Final **Physician** cell non-small disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, framy leading immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner The law requires that the death certificate be executed use as the burial-transit that initiated events resulting in death) Last physician and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 menths? Day 4☐Pregnant at time of death 5 Other (specify) signed by the all d be detached for ☐Yes 2 🗹 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 Probably 4 Unknown Completed peeu 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No page 2 s 2 No 2 No certificate 1 Yes or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 1 Yes 2 No 2 4 ■ Nursing Home 5 □ Residence 6 □ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 1 ☑Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred in by the funeral Certification: After 5 Pending 1 ☐ Yes 2 ☐ No investigation within 24 hours after death.

To the Funerel Director: A 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide To the Hospital 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medicai 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier

State Registrar

State 31 Date filed (Month, Day, Year) \\
NOV 0 3 2004

VIS

Knhn

32. Registrar's Signature

and address of person who completed cause of death (Item 23a) (Type, Print)

MD.

MO

Montrose Road nature & Sporks Rockville, MD

			1 - For State Registrar	State of Marylar	•	artmer rtificat			ind M e		giene Reg. No.	004	36571
	Physici /Medic		Decedent's Name (First, Middle, Las FRANK JACKS)	ON BURTON		4. 05				2. Date of Dea Month OCTOB	ER 2	9 200	
L	Examin	ner	4a. Facility Name (If not institution, give Union Hospita: 5. Social Security Number 6. Se		last birthday)	E	Lkto	Location of n If Under 2		B. Date of Birtl	C	ecil 9. Birt	h hplace (State or Foreign untry)
	Funeral Director		219-16-9561 Usual Residence of Decedent	OM 2□F 93	Yrs.	Months	Days	Hours	Min.	(Month, Day ec 16	191		ryland
.UU36 hours after death with the Maryland	"natural", or items 23a or 28a-f show witcal Examiner must be notified at	by Funeral Director	10a. State 10b. County MD Cecil 10e. Street and Number 172 Center St. 1 Never Married 2 2 Married 3 Widowed 4 Divorced 10b. County			on 10f. Zip	1913 dent of His cry Cubar	spanic Orig n, Mexican	gin? (Spec , Puerto Rí	ify Yes or No- can, etc.)	U.S.	Race - Ame Black, White	rican Indian,
-C1212	ital Hygiene. id other than event, It e M	Be Completed	17. Father's Name (First, Middle, Last)								Corp		Engineers
Maryland nd 2 should be file	f Health and Men item 27 is marke other traumatic	ပ	19a. Informant's Name/Relationship (19alter Burton			•			r or Rural	Route Numbe	•	own, State, 2	
Baltimore, permit. Pages 1 a	Department of Health ar Important: If item 27 Is any injury or other trauonce.		20a. Method of Disposition 132 Burial 2 Cremation 3 C 4 Donation 5 Other (Specify 21. Signature of Federal Service Lice	Z:	Place of Disponential Place of Disponential	emete ^{2. Name a} 1 en a	ery	s of Facility nera	11/3 1 Ho	/04 me of	Cec Ste	phen	L. Schaech
60, be executed 四一世	ysician and Medical kaminer transit	icai Examiner	23a. Part - Enter the disease, or com shock, or heert failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underfying Cause (Disease or injury that initiated events resulting in death) Last	olications that caused the dea	th. Do not enguence of):	ter the mod	de of dying	g, such as	cardiac or		rest,		216.35 Approximate Interval Between Onset and Death
O. Box 687.	by the attending photached for use as to	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnancy 1 Live birth 2 Fetel death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify)							230	ivery Day Year	
Division of Vital Records, P.O or Attending Physician: The law requires that the	ate has been signed page 2 should be de	Completed by Pt	Part II. Other significent conditions o	ontributing to death but not re	sulting in the u	underlying	cause give	en in Part I.		1 TY	res 2□n	No 3 ☐ Pr	othe cause of death? obably 4 Munknown stopsy findings available completion of cause of
Vision of Vita Attending Physician:	. <u>ē</u> ē	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No 27. Manner of Death 1 ☒ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	ER/Outpatie 28b. Time o Injury		28c. Injury Work	er: 4 🗆 Nu	rsing Hom	(Check only only only only only only only only	ience 6		cify)
DIVISI tal or Atter	rs after death. el Director: A ed in by the fu	Certification;	3 Suicide 6 Could not b 4 Homicide determined	28e. Place of Injury - At h building, etc. (Spec	nome, larm, st	reet, factor	y, office		28	BI. Location (S City or Tow	Street and N m, State)	Number or Ru	iral Route Number,
To the Hospi	within 24 hours after death. To the Funerel Director: Af completely filled in by the fu	Medical		ysicien: To the best of my kn niner: On the basis of examin and manner stated.		nvestigation 29		oinion, deat		d at the time, o	date and pl	ace, and due	
	St: Regist	ate	30. Name and address of person who Ashok Subrama 31. Date liled (Month, Day, Year)		ion H	lospi		106	Bow	St.			D. 21921

State of Maryland / Department of Health and Mental Hygiene For State Registrat Reg. No. 2004 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** 10:45a[™] OCTOBER CATHERINE BELL BURTON 30 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 172 Center St. 2-DApt. Cecilton Cecil If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Qay, Jan 6 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🔀 F 92 1912 Director Maryland 219-34-1840 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10d. Inside City Limits 10b. County 28a-f show itam 27 is marked othar than "natural", or Items 23a or 28a-f shov other traumatic evant, the Medical Examinal must be notified at MD Cecil Cecilton 1X Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with Apt. 2-D 21913 172 Center St. U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 No If Yes, Give Year or Dates: Specify 3X Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If itam 27 is marked other than any injury or other traumatic event. If e Ma Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 7 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Leonard Dixon Anna R. Holding 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 424 Elk Mills Rd. Elkton, MD. 21921 (son) Walter Burton 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1

Burial 2 □ Cremation 3 □ Remoyal from State 4 Donation 5 Duher (Specify) 11/3/04 Zion Cemetery Cecilton, MD. 22. Name and Address of Facility
Galena Funeral Home of Stephen L Schaech 21. Signature of Eureral Service once M00510 118 West Cross St. Galena, MD. 21635 Approximate Interval Between Onset and Death Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or head failure. List only one cause on each line. Immediate Cause Final Priysician 110 Dulmoradisease or condition resulting in death /Medical -12 Due to (or as a consequence of): Examiner Melanoma Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a nonsequence of) anding physician and use as the burial-transit resulting in death) Last Due to (or as a consequence of): ed by the attending physician detached for use as the burial P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Year Day 5 Other (specify) 9 Unknown cate has been signed by a page 2 should be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 1 ☐ Yes 2 No 3 Probably 4 □Unknown Completed certificate has been 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☒ No 24a. Was an was an autopsy performed? 1 ☐ Yes 25. Was case referred to medical examiner?
1 ☐ Yes 2 No Be 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home Sesidence 6 ☐ Other (Specify) Hospital: 1 | Inpatient 2 | EP/Outpatient 3 | DOA 10 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation after death 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospital within 24 hours a To the Funeral C Hospital 29a. Certifier 🔁 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cal (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier HOO 56 426 30. Name address of person who commed ed cause of death (Item 23a) (Type, Print) 251 S. Bohemia Ave. Cecilton, MD. 21913 Paul Katz M.D. 31. Date filed (Month, Day, Year) 32. Registrads Signature State NOV 0 4 2004 Registra

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 36573 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 09:00 AM **Physician** Charles Deery Beale OCtober 27, 2004 /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 355 Worsell Manor Road Warwick Cecil If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days **f**X□M 2□F 165-05-1460 89 06/10/1915 Director Pennsylvania Usual Residence of Decedent 10d. Inside City Limits death with the Maryland 10c. City, Town or Location 10a. State 10b. County and 2 should be filed within 72 hours after death with the Marylan leath and Mental Hygiene.

m 27 is marked other than "neturel", or Items 23s or 28a-f show her traumatic event, it a Medical Examinar must be notified at 1 Yes 2 No Director Maryland Cecil Warwick 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 355 Warsell Manor Road 21912 USA by Funeral 14 Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Specify: White 3 ₩idowed 4 Divorced Completed 16b. Kind of Business/Industry 16a, Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) 12 Paper Maker Paper 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Charles Beale Ann Deery 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 Department of Health a Important: If item 27 is eny injury or other trai 900. 355 Worsell Manor Road, Warwick, Maryland Dennis Beale /Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stete 20a. Method of Disposition Date 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Chesapeake Cremation Center 10/28/2004 Stevensville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Fellows Helfenbein Newnam Funeral Hore
370 W. Cypress Street, Millington, MD 21651 21. Signature of Funeral Service Licensee P.A. breat eller Approximate Interval Between Onset and Death 11. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Arterioscleratic Cardiovas cular disease Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leeding to immediate cause. Enter underlying Cause (Disease or injury Due to (or as a consequence of) Examiner attending physicien and for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Year Day 4☐Pregnant at time of death ☐Yes 2☐No 9 Unknown 9 Unknown signed by I 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ of the Alzheimer 1 Yes 2 No 3 Probably 4 Munknown Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No has certificate 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 A Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No neret Director: A 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier October 27, 2004 D0035779 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 25/5. So he mia Arc.

W. Bruce Obershain, m.B., Lecilton, Maryland 21913-0670

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

OCT 2 8 2004

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

32. Registrar's Signature

			1 - For Stata Registrar	State of M	aryland / Dep <i>Ce</i>	artment of rtificate of	Health a	and Mental Hy	giene 0	04	36574
	Physic /Medi	cal	1. Decedent's Name (First, Middle, Last Martha Arde	ella B	arnard			2. Date of De Month October	30°, 2	2 0 0 4	3. Time of Death 1:00P M
	Examii	ner	4a. Fecility Name (If not institution, give 12109 Silver 1 5. Social Security Number 6. Se	Maple Dr	ive	4b. City, Town, Waldo If Under 1 Year	rf		(y of Death	les
	Funeral Director		362-34-5714 Usual Residence of Decedent	M 2 ∑ F	72 Yrs.	Months Days	Hours	Min. 8. Date of Bir (Month, Da March	1932	9. Birth	place (State or Foreign ntry) MI
	e Marylani 3a-f show Lilled at	ctor	MD 10b. County Charle	es	10c. City, Town or Lo	orf				1	10d. Inside City Limits
	ath with th	ral Dire	10e. Street and Number 12109 Silver Ma	aple Dri	.ve	10f. Zip Code 20	601		10g. Citizen of USA	What Cour	ntry?
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, Ira Medical Erath er mind be revisited at once.	Completed by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Armed Forces? 1 Yes If Yes, Give Year or Dates:	No	Was Decedent of If Yes, specify Cub 1 ☐ Yes 2 XNo		in? (Specify Yes or No Puerto Rican, etc.)	- 14. Ra Bla Specii	ce - Americ ick, White, fy:	
Maryland 21215-0036	within 72 ho ene. then "natur ne Medical	ompleted	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)		(Give	dent's Usual Occu kind of work done DO NOT use retire	during most ed)	of working	16b. Kind of B		dustry
/land 2	uld be filed Mental Hygi srked other stic event, u	To Be Co	17. Father's Name (First, Middle, Last) Ray McHenney		Sw	Leciman		's Name (First, Middle, a Heike			Company
, Man	and 2 sho Balth and I n 27 is me		19a. Informant's Name/Relationship (T) Janice Gilroy/			ng Address (Street Linden	t and Number Lane	or Rural Route Number, La Plata	er, City or Town,	State, Zip 0646	Code)
Baltimore,	t. Pages 1 rtment of H rtant: If itan		20a. Method of Disposition ↑□ Burial 2 □ Cremation 3 □ F ↑4 □ Donation 5 □ Other (Specify)		Trinity	Memori	al Ga	nr.11/4/04		orf,1	Maryland
Ba	Depa Impo any ir		21. Signatule of Funeral Service Licens	hold		P.O. BO	X 567	LS FUNERA LA PLATA	A, MD.		
	Physician /Medical		23a. Part1. Enter the disease, or compishock, or heart failure. List only of immediate Cause (Final disease or condition resulting in death)	a Rup	a consequence of):	Aortic	Ai	neurysn			Approximate Interval Between Onset and Death
8760,	death centificate be executed by a strength of the set	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as	a consequence of):	Tam	ponc	de			
.O. Box 6	at the death certificaby the attending place to use as t	Physician/Med	IF FEMALÉ: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ℚ No 9 □ Unknown	3c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 ☐ Fetal death 3 ☐	Ectopic pregnanc	у			te of deliver	ry Day Year
ords, P	The law requires that the tee has been signed by the sage 2 should be detache	by	Part II. Other significant conditions cor	itributing to death bu	at not resulting in the ur	nderlying cause giv	ven in Part I.				e cause of death?
Vital Records,		Completed						24a. Was a autope perfor 1 XYes	med?		psy findings available apletion of cause of
Division of Vit	utending Physideath.	ertification; To Be	27. Manner of Death 1 Notural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be	ospital: 1 ☐ Inpatie 28a. Date of Injur (Month, Day	y 28b. Time of Injury	28c. Injur Wor M 1 □	ler: 4 ☐ Nurs		ence 6 Other	ed	
2	ospitel or A hours after merel Direct y filled in by	O	4 ☐ Homicide determined 29a. Certifier 1 ₩ Certifying Phys	building, etc	of my knowledge death	Occurred at the tir	ne, date and	28f. Location (Si City or Town place, and due to the c	n, State)	anor on other	
	To the Hospitel of within 24 hours at To the Funerel D completely filled i	Medical	(Check only 2 ☐ Medical Examinations) 29b. Signature and title of centrier	ner: On the basis of and manner sta	examination and/or inv	estigation, in my o	e number	occurred at the time, d	ate and place, a	and due to	the cause(s)
1	BIN		30. Name and address of person who co Paul Bone, M.D.	mpleted cause of de	eath (Item 23a) (Type, I Fort Wash	Print) ington	∀62 Rd. F	Fort Wash:	// /c ington	, MD	en 4 20744
7	Sta Registra	_	31. Date filed (Month, Day, Year) NOV 0 3	20 De-	r's Signature				<u> </u>		

na 15,10	, 17	For State of Marylar 1 - State Registrar	nd / Depa	artment of Health a	and Me	ntal Hygie		36576
Physic	ian	1. Decedent's Name (First, Middle, Last)		-	2	Date of Death Month OCtober	Day Year Z Zco4	3. Time of Death
/Medi Examii		4a. Facility Name (If not institution, give street and number) Merch Medical Center		4b. City, Town, or Location	of Death Marn		4c. County of Death	ore City
Funeral Director			. last birthday) Yrs.	If Under 1 Year If Under Months Days Hours	24 Hrs. 8 Min.	Date of Birth (Month, Day, Ye	ar) 9. Birthp Cour	place (State or Foreign otry) MS
aryland how	<u>_</u>	Dr. 2	ity, Town or Lo	/			1	0d. Inside City Limits 1 X Yes 2 □ No
th the Ma or 28a-f)irecto	10e. Street and Number	slom	10f. Zip Code		10g.	Citizen of What Cour	
death wi	Funeral Director	11. Marital Status 12. Was Decedent Ever in Larmed Forces?	J.S. 13.	2 / 0 4, Was Decedent of Hispanic Or If Yes, specify Cuban, Mexical		fy Yes or No- can, etc.)	14. Race - Americ Black, White,	
ours after	by	1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates:		1 ☐ Yes 2 No Specify:		, , , , , , , , , , , , , , , , , , , ,	Specify: B/	
Dalfill Mofe, INIaty Idilia Z Z 23-0030 permit. Pages 1 and 2 should be filed within 72 hours atter death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other then "natural", or items 23a or 28a-f show may nighty or other traumatic event. Ite Medical Examination modified at once.	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) Coltege (1-4or 5+)	(Give	dent's Usual Occupation kind of work done during mos DO NOT use retired)	st of working	16b	. Kind of Business/In	dustry
filed will hygien I other th	Be Cor	0 0 17. Father's Name (First, Middle, Last)	1			First, Middle, Maid		
Should b of Ments marked	10	Elmer Cruz 19a. Informant's Name/Relationship (Type, Print) Mo Fusik	19b. Maili	ng Address (Street and Numb	er or Rural F	Route Number, Ci		
C, NG 1 and 2 a Health ar em 27 is ther trau		1 ESENIA CRUZ	Place of Dispr	24 TAMO	R Dat		mbia M	9 21045 own, State
Datumor Demit. Pages Department of mportant: If it it in violary or o once.		1 ☑Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	odlawn				odlawn, Ma	
Departition of the control of the co	-	21. Signature of Funeral Service Licenses		2. Name and Address of Facili Sterling Asht 736 Edmondsor	n Aven	ue; Cato	eral Home nsville, l	4D 21228
Physician		23a. Part1. Enter the disease or complications that caused the dea shock, or heart failure. List only one cause on each line.			s cardiac or r	respiratory arrest,		Approximate Interval Between Onset and Death One hour
/Medical Examiner	ı	disease or condition resulting in death) a. Due to (or as a conse	quence of).	rematurity nt cervix				0710-11001
ned %	Examiner	Sequentially list conditions, if any, legading to immediate cause. Enter Underfying Cause (Disease or injury					Ta	
ate be executed hysicien and the burial-transit	cal Exa	that initiated events resulting in death) Last C. Due to (or as a conse	quence of):					
Certific		IF FEMALE: 23b. Was decedent pregnant			25.		23d. Date of delive	ery
. 0 0 0	Physician/Med	1 Live birth 2 Fel to the past 12 months? 1 Yes 2 No 9 Unknown		□Ectopic pregnancy □ Other (specify)			Month	Day Year
v 8 8 8	þ	Part II. Other significant conditions contributing to death but not re	sulting in the u	inderlying cause given in Part	1,	23e. Did tobac	co use contribute to to	ne cause of death?
e law	ompleted					24a. Was an autopsy performed	prior to co death?	psy findings available mpletion of cause of
Or VICAL Physician: The This certificate ral director, pag	BeC	25. Was case referred to medical examiner? Hospital:	Title 224	Other		1 ☐ Yes 2 ☑ Check only one)		COLUMN THE STREET
Phys r this	on: To	1 ☐ Yes 2 ☑ No	28b. Time of Injury	of 28c. Injury at Work?	28	5 ☐ Residence d. Describe how i	e 6 □Other (Specifinjury occurred	y)
Atten deal ctor	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At building, etc. (Spec	home, farm, st	M 1 Tes 2 Teet, factory, office		f. Location (Stree City or Town, S	t and Number or Rura tate)	al Route Number,
Hospital or / 24 hours after Funeral Dire	edical Ce	29a. Certifier 1 ☐ Certifying Physician: To the best of my kr (Check only 2 ☐ Medical Examiner: On the basis of examin						
To the P within 2. To the F complete	Med	one) and manner stated. 29b. Signature and title of certifier	1-1-0	29c. License number	.10	29d.	Date signed (Month,	Day, Year)
.		30. Name and address of person who completed cause of death (lite	em 23a) (Type	Print) 1 01	92 5tc 6	121 0	Liver &	21,2004 mDZIZOZ
St.	ate	Dr Tara Defampert 50 31. Date filed (Month, Day, Year) 32. Røgistrar's Sign	21 5t	Paul YI	JTC "	121 130	stimore ,	1021012
Regis		NOV 1 8 2004		apours				

tem 15, 100-6, 17,29d

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? On the

			1 - State Registrar		C	ertificate of	Death	Re	ene2004	
	Physici /Medic		1. Decedent's Name (First, Middle, Isaiah Chandler						Day Year 30, 2004	3. Time of Death
	Examin Funeral Director	ier	4a. Facility Name (If not institution, § 3402 Lancer Dri: 5. Social Security Number 251-84-4802	ve	e (In yrs. last birthda 56 Yrs.	Hyatts Hyatts Hyatts Hyatts Honder 1 Yea	r If Under 24 Hrs.	8. Date of Birth	Prince Ge Yeer) 9. Birth	
	D D		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or	Location		June 24,	1940 5000	10d. Inside City Limits
	death with the Maryland ms 23e or 28a-f show rmast be notified at	Director	MD Prince	Georges	Hyattsvi	11e		10	g. Citizen of What Co	1 🔀 Yes 2 🗆 No untry?
	leath with	Funeral D	3402 Lancer Dri	12. Was Decedent	Ever in U.S. 1	2078 3. Was Decedent of If Yes, specify Cu		pecify Yes or No-	USA 14. Race - Amer	
0000	urs after d sl', or Iten	by	1%∑ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces?		If Yes, specify Cu 1 ☐ Yes 2 🖫 No		o Rican, etc.)	Specify: B1a	•
0-017	be filed within 72 hours after death with the Marylan tal Hygiene d other than "natural", or Items 23e or 28a-f show event, the Medical Examination at the notified at	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12) 12th	Education grade completed) College (1-4or 5	5+) (G life	cedent's Usual Occi ive kind of work don b. DO NOT use retir	ipation e during most of wor ed)	rking	6b. Kind of Business/l	ndustry
and 2		Be	17. Father's Name (First, Middle, La Sharper Chandle			TELK		ne (First, Middle, M th Pender	laiden Sumame)	
Mary	DENE	2	19a. Informant's Name/Relationship Lula Chandler/s	(Type, Print)		-	at and Number or Ru	ıral Route Number,	City or Town, State, Z Maryland	
nore,	permit. Pages 1 and 3 Department of Health Important: If item 27 sny injury or other tr <u>once</u> .		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe	☐Removal from State	20b. Place of Dis	sposition (Name of crematory or other pl	ace)	Date 2	Oc. Location - City or	Fown, State
Daitimor	permit. P Departme Importar sny injur		21. Signatur of Funeral Service Lie			22. Name and Addi	ress of Facility J	.B. Jenki	ns Funeral Maryland	Home
查 (2)	Physician	10	23a. Part1. Enter the disease, or conshock, or heart failure. List or Immediate Cause (Final disease or condition		the death. Do not ne.				st,	Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as	a consequence of):					
pa/pn,	ificate be executed g physician and as the burial-transit	edical Examiner	f any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	a consequence of): a consequence of):					
O. BOX 68	death certi e attending ed for use a	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant al	2 Fetal death	3 □Ectopic pregnan 5 □ Other (specify)	су		23d. Date of delin	very Day Year
ras, r	requires that the een signed by th hould be detache	by	Part II. Other significant condition	s contributing to death b	out not resulting in the	a underlying cause g	iven in Part I.		acco use contribute to	11
Vital Records,	The law ate has b page 2 sl	Completed						24a. Was an autopsy perform	24b. Were auf prior to c death? The No 1 Yes	topsy findings available ompletion of cause of 2凶No
ō	ding Phys h. Alter this funeral di	ıtlon: To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investiga	Hospital: 1 Inpatie 28a. Date of Inju (Month, Da	ry 28b. Time	e of 28c. injury	ther: 4 🗆 Nursing H	ath (Check only one lome 5 Resider 28d. Describe how	nce 6 Other (Spec	ify)
DIVISION	⊒ Pite	Certification:	3 Suicide 6 Could no 4 Homicide determin	ad 286. Place of in	ury - At home, farm, c. (Specify)	street, factory, office	9	28f. Location (Stre City or Town,	eet and Number or Ru State)	ral Route Number,
	To the Hospital within 24 hours a To the Funeral I completely filled	Medical	(Check only 2 Medical Ex	Physician: To the best kaminer: On the basis o and manner st	f examination and/or	investigation, in my	opinion, death occu	rred at the time, da	te and place, and due	to the cause(s)
)	(D)	-	29b. Signature and title of certifier	true O	rus w	S) M	258	47	d. Date signed (Month $11-3-01$	L . Jay, 1641)
_			30. Name and address of person w James Oliver M.I 31. Date filed (Month, Day, Year)	0. 5422 Firs			ington, Do	20011		
	Sta Regist	ate rar	NOV n 4 21		L. J Digitator 6	Contra				

			1 - For State Registrar	State of Marylan		artmen			nd Me	_	giene Reg. No. 2 (004	36578
	Physici /Medic	al	Decedent's Name (First, Middle, Last,	CALA	BR	4b. City,	SE Town, or L	ocation of		2. Date of De. Month	ath Day	Year O L	3. Time of Death
	Funeral Director		093-30-1119	x 7. Age (In yrs.	last birthday) 95 Yrs.	Ch If Under Months	ever] 1 Year Days	Ly If Under 24 Hours		8. Dete of Birt (Month, Da Jan • 0	h	9. Birthpi	orge's ecs (State or Foreign fry) S, Italy
	permit. Pages 1 and 2 should be filled within 72 hours atter death with the Manyland Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at ance.	uneral Director	Usual Residence of Decedent 10a. State 10b. County Maryland Prince G 10e. Street and Number 3628 Morningside I 11. Marital Status 1 Never Married 2 Married	eorge's B	y, Town or Lo	10f. Zip	0715	panic Origi , Mexican,	in? (Spec Puerto R	cify Yes or No	Blac	Whet Coun	an Indian, atc.
Maryland 21215-0036	filed within 72 hours att Hygiene. other than "natural", or ant, the Medical Exam	e Completed by Funeral Director	3 Widowed 4 Divorced 15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12) 17. Father's Name (First, Middle, Last)	If Yes, Give Year or Dates:	16a. Dece	dent's Usua kind of wo DO NOT us on De	al Occupat rk done du se retired)	ering most o			Specify 16b. Kind of Bu Garment Maiden Suman	Indu	lustry
Marylan	d 2 should be th and Mental if is marked of traumatic eve	To Be	Giuseppe Calabro 19a. Informant's Name/Relationship (7) Carolina C. Stalli	rpe, Print)			(Street an	nd Number	or Rural		er, City or Town,		
Baltimore,	permit. Pages 1 and 2 Department of Health a Important: If Itam 27 to any injury or other tra once:		20a. Method of Disposition 1 Burial 2 Cremation 3 F 4 Donation 5 Other (Specify)	Removal from State For	Place of Dispo semetery, crei t Linc	osition (Name matory or o	ne of ther place) emete	ery 1	Da 1/05/	/2004	20c. Location - Brentwo	od, M	wn, Stete
Bal	permit Depar Impor any in		23a. Part1. Enter the disease, or compleshock, or heart failure. List only of	M. BCAT	CAR 6	512 N	W Cra	ain Hy	wy. I	Bowie,	eral Hom Marylan rest,		715 Approximate Interval Between
	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	a. Due to (or as a conseq	CHRI	DIV					ROTOR	1	Onset and Death
8760,	ate be executed hysicien and the burial-transit	lical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conseq Due to (or as a conseq d.									
P.O. Box 6	the death certifica y the attending ph sched for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of pregna 1 Live birth 2 Feta 4 Pregnant at time of d	Ideath 3	Ectopic pr					23d. Dat Mo	te of delive	ry Day Year
Records, P	The law requires that the de ate has been signed by the a bage 2 should be detached f	by	Part II. Other significant conditions co	ntributing to death but not res	ulting in the u	nderlying c	ause given	in Part I.	*			ribute to th	e cause of death?
	n: The law r ificate has be or, page 2 sh	Completed	25. Was case referred to medical	(4EV	251	73	200	OS Plans		1 Yes	rmed?	prior to con leath?	osy findings available apletion of cause of
Division of Vital	ing Physician: Vier this certific uneral director,	on; To Be	axamina(?	Hospital: 1 Inpatient 2 28a. Date of Injury (Month, Day Year)	ER/Outpatier 28b. Time o Injury	f 2	Other 8c. Injury a Work?	4 □ Nurs	sing Home		lence 6 Other)
Divisio	To the Hospital or Attending Physician: The i within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Certification;	2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place of Injury - At he building, etc. (Specif		meet, factory		es 2 □N	-	Bf. Location (S City or Tow	Street and Numb m, State)	er or Rural	Route Number,
	To the Hospital or within 24 hours at To the Funeral Dicompletely filled in	Medical (29a. Certifier 1 CertifyIng Phy (Check only 2 Medical Exami one) 29b. Signature and title of certifiels	sician: To the best of my kno ner: On the basis of examina and manner stated.	owledge, deat tion and/or in	vestigation,	at the time , in my opin c. License	nion, death	place, an	d at the time, o	cause(s) and madate and place, a	and due to	the cause(s)
0	2		30. Nam and address of person who co	mompleted cause of death (Item	n 23a) ype,	De	00200				11/3	100	4
	Sta		Sudhakar Punja 72 31. Date filed (Month, Day, Year) NOV n 4 2004	19B Hanover Pl		renbe	1t, M	ary1a	and 2	0770		<u> </u>	

Charlie Cain 04-07221 RJ

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72:	21		1 - State Unpend Item 23	State of Maryland	d / Depa	rtment of	Health and I	Mental Hy	giene	004	36579
					"Cel	tificate of	Deăth	2. Date of De			3. Time of Death
т	Physicia	ın	1. Decedent's Name (First, Middle, Last)	oma a Ca	٠					, 2004	02:27 A.M
ı	/Medic		Charlie Th	nomas Ca:	Ln	4b. City, Town,	or Location of Death			County of Death	02.27 A.
	Examin	er	Prince George's Cou			Chever]			Pr	ince Geo	orge!s
I	Funeral Director		5. Social Security Number 6. Sex	7. Age (In yrs. I	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs.	8. Date of Bird (Month, Da Feb. 14	th y, Year)	9. Birthp Cour 70 Wash	place (State or Foreign
	and w	ĺ	Usual Residence of Decedent 10a. State 10b. County	10c. City	y, Town or Lo	cation			-	1	10d. Inside City Limits
	Maryl 1 sho	tor	Md. P.G.	Car	oitol	Hghts,	Md.				1 ∑ Yes 2 ☐ No
	n the	by Funeral Director	10e. Street and Number			10f. Zip Code			10g. Citi	zen of What Cour	ntry?
	23a c 23a c ust bs	aiD	411 Clovis Ave			20743			U.S		
	er dea	nue	11. Wantar States	Was Decedent Ever in U. Armed Forces?	S. 13. \	Was Decedent of Yes, specify Cul	Hispanic Origin? (S ban, Mexican, Puert	pecify Yes or No o Rican, etc.)	-	 Race - Americ Black, White, 	
36	irs after	by F	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes A☐No If Yes, Give Year or Dates:		I□Yes 25 No	Specify:			Specify:Blac	ck
P P	be filed within 72 hours after death with the Maryland ital Hyglene. do other than "natural", or Items 23a or 28a-f show event, the Modical Ever it at most be recitified at	ted	15. Decedent's Educ (Specify only highest grade	cation	16a. Deced	lent's Usual Occu	ipation	tkina	16b. Ki	nd of Business/In	dustry
215	ithin 7	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	Barbe		ed) during most of wor	9	Sel	f	
22	filed w Hygier other th		12th 17. Father's Name (First, Middle, Last)		barbe	= L	18. Mother's Nar	ne (First, Middle	L		
Baltimore, Maryland 21215-0036	hould be f id Mental h marked ol matic eve	To Be	Charlie Cain Jr	40.9			Mary W	right			
Mar	permit. Pages 1 and 2 should Department of Health and Men Important: If item 27 is marke any injury or other traumatic once.		19a. Informant's Name/Relationship (<i>Typ</i> Wargaret Cain-S				at and Number or Ru Ave Cap:				
ore,	Pages 1 and nent of Heamant: If item		20a. Method of Disposition 1 ☐ Burial 2☐€ remation 3 ☐ Re		emetery, crer	sition (Name of natory or other pl	ace)	Date 1 – 1 2 – 0 4		cation - City or To	
altim Tim	nit. Pa vartmen ortant: injury e.		'4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Septice License	4	22	. Name and Add	ress of Facility				1100
ñ	permi Depa Impo any ii		anet C.	maleson	Di	ınn & S	ons 563!	Eads	St,	N.E.	
	Physician		23a. Part Enter the disease, or complice shock, or hear failure. List only one immediate Cause (Final disease or condition	cations that caused the death e cause on each line. Narcotic(her					rrest,		Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a conseq							
B	Lxammer	<u>_</u>	Sequentially list conditions, if any, leading to immediate cause, gifter underlying	Due to (or as a conseq	uence of):						
	uted I Insit	Examiner	Cause (Disease or injury								
oʻ	ate be executed hysician and the burial-transit	Еха	that initiated events c. resulting in death) Last	Due to (or as a conseq	uence of):						
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Box	attend for us	ian/	in the past 12 months?	3c. If yes, outcome of pregna 1□Live birth 2□Feta 4□Pregnant at time of d	Ideath 3	Ectopic pregnan Other (specify)	су			23d. Date of delive Month	ery Day Year
o.	that the de led by the a detached f	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9 Unknown		Journal (Speemy)					79.00
S, D	res that igned b be deta	y Pł	Part II. Other significant conditions con	tributing to death but not res	ulting in the u	nderlying cause g	oven in Part I.	23e. Did t	obacco u	ise contribute to t	he cause of death?
ğ	w require been sig should b							1 🗆	Yes 2	□No 3□Prob	pably 4 □Unknown
Record	KI SI CA	Completed						24a. Was auto	psy	prior to co	opsy findings available impletion of cause of
<u>س</u>	: The l	Con						12 Yes	rmed? 2□ No	death? 1 X Yes	2□ No
Vital	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	lospital:	ED/O			ath (Check only o		C Cohor (Coord	4.1
o	Phys r this sral di	: To	Yes 2 No 27. Manner of Death	i L inpatient 2 🗷	28b. Time o	28c. Inj	ther: 4 Nursing Fury at	28d. Describe			ry)
on	Attending of death. ector: After by the funer	atior	1 □Natural 5 □ Pending 2 □ Accident investigation	28a. Date of Injury (Month, Day Year) Found:	Found 1:40		ork? ⊡Yes 2. X No	Unknow	m		
Division of	l or Attend after death Director: ,	Certification:	3 ☐ Suicide 6 🏋 Could not be 4 ☐ Homicide	Pice Pice At he building, etc. (Specific Found at res	ome, farm, str	reet, factory, office	Э			d Number of Rura) 411 Clo phts Ma	Nymber, Over Avenue
_	Hospita 24 hours Funeral tely filled	edicai C		sician: To the best of my knoner: On the basis of examina and manner stated.	wledge, deat	h occurred at the		e, and due to the	cause(s)	and manner as s	stated.
	To the within 2 To the complet	Med	29b. Signature and title of certifier	and marrier stated.			nse number			te signed (Month,	
1	E » E o		> Zahim	las Al	7		CME		No	vember 8	, 2004
D	L(1)		30. Name and address of person who co	impleted cause of death (Iter	n 23a) (Type, 111	Print) Penn St i	reet, Balt	timore,	Mary	land 212	201
	Sta		31. Date filed (Month, Day, Year) NOV 1 5 2004	2. Registrar's Signa	ature	M e					
	Regist	ai	TOOL TOOL	LEGINA A	11						

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Dey, Year)

NOV 0 3 2004

32. Redistrar's Signature

		1	For State Registrar	State of Ma	ryland / Dep <i>Ce</i>	artment of ertificate o		Mental Hy	giene 0 0	14 36581
			Decedent's Name (First, Middle, Las	t)				2, Date of De	aath	3. Time of Death
	Physicia		Fathor	Helen	Cami	obell		Month Nov C	Day 12, 2004	Year 4 11:59P ^M
	/Medic Examin		Esther 4a. Facility Name (If not institution, give		Cam		n, or Location of Dea		4c. County o	
	EXAMINIT	C1	Union Hospital		· Ctroot	Elkto	on, Marv	land	Ceci	: 7
	Funeral		5. Social Security Number 6. Se	7. Age	(In yrs. last birthday) If Under 1 Ye	ar If Under 24 Hrs	S. 8. Date of Bi	rth	9. Birthplace (State or Foreign
	Director		181-52-0372	⊐м ¾ ДF	87 Yrs.	Months Da	ys Hours Min	Oct 30		Country) Pennsylvania
	ט	-	Usual Residence of Decedent							
	how		10a. State 10b. County		10c. City, Town or t	ocation.				10d. Inside City Limits
	a-f s	cto	PA Chester		Nottine	gham				1 ☐ Yes 24 ☐ No
	th th	Director	10e. Street and Number			10f. Zip Cod	le		10g. Citizen of W	'hat Country?
	th wi		52 Sunset Drive				362		United	States
	ems erm	Funerai	11. Marital Status	12. Was Decedent B Armed Forces?	Ever in U.S. 13	Was Decedent	of Hispanic Origin? (Suban, Mexican, Pue	Specify Yes or No rto Rican, etc.)	o- 14. Race Black	- American Indian, k, White, etc.
٥	or it	F	1 Never Married 2 Married	1 □ Yes 2 💢 N If Yes, Give	lo	1 ☐ Yes 2 % ☐	No Specify:		Specify:	T. T. T. A.
Š	filed within 72 hours after death with the Maryland Hygiene. Hygiene, so them and marker show ant, the Maryleal Examiner must be notified at any.	d by	3 ₩ Widowed 4 □ Divorced	Year or Dates:						wnite
<u>v</u>	nat	Completed	15. Decedent's Ed (Specify only highest gra		(Giv	edent's Usual Oc e <i>kind of work d</i> o <i>DO NOT</i> use re	one during most of wo	orking	16b. Kind of Bus	siness/industry
7	withir ne. ihan	d II	Elementary/Secondary (0-12)	College (1-4or 5	+)		, and the second		,,,	T
7	Hygie Hygie Ther t		17. Father's Name (First, Middle, Last)		HOI	nemaker		ame (First, Middle	, Maiden Sumame	Home
שֱב	ed tal	Be								•
altimore, Maryland 21215-0036	s 1 and 2 should be filed within 72 hours after death with the Marylan Health and Menth Hygiene. Health and Menth Hygiene Health and Menth Hygiene Health and Sa or 28a-1 show tem 27 is marked other than "natural", or litems 23a or 28a-1 show tem 27 is marked other traumatic evant, it a Moulcal Examiner must be notified at	2	John Edward Wi		19h Mai	ling Address (Str	reet and Number or F	Davis		State Zin Code)
M	h an 7 Is r traur									
a J	1 and Health em 27 ther to		Mary V. Osborr 20a. Method of Disposition	<u>ie</u>	20b. Place of Disp	osition (Name o	f	Nottin Date	gham, E	PA 19362 City or Town, State
ŏ	Pages nent of I int: if it		f Burial 2 ☐ Cremation 3 ☐			ematory or other	place) Siends No	or 6 0.4	N 0-	*
ţ	permit. Pages 1 and 2. Department of Health at Important: If Item 27 Is any injury or other traugues.		'4 □ Donation 5 □ Other (Specify			22. Name and Ad	delega of Facility			
Bal	permit. Departri Importa any inji		21. Signature of Funeral Service Licen	300			(nd & Go	
	TD 2 4 0		23a. Part1. Enter the disease, or com	DVW	the death. De set o	221-223	Pennasy	ylvania	Ave. A	Avondale PA
			shock, or heart failure. List only	one cause on each lir	10.	inter the mode of	dying, such as cardi	ac or respiratory a	111631,	Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)	a	AWTE R	ESTILATOR	y faiwer			1 DAY
r	/Medical Examiner		lesulting in death)	Due to (or as	a consequence of):		_			
	LAGIIIIICI		Sequentially list conditions,	b	a consequence of):	hear	T FAILURE			ONFUM
	be sit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as		۸.				
	and and I-tran	хап	that initiated events resulting in death) Last	c. Due to (or as	a consequence of):	ATHY				Chickeny
8760,	icate be executed physician and s the burial-transit	田田								
87	physic the	dicai		d						
9 xo	The law requires that the death certific the has been signed by the attending prage 2 should be detached for use as	Physician/Me	IF FEMALE:	23c. If yes, outcome	of pregnancy				22d Date	e of delivery
Bo	atten for u	ian	23b. Was decedent pregnant in the past 12 months?		2 Fetal death 3	☐ Ectopic pregna			Mon	,
o.	the d	ysic	1 ☐ Yes 2 ØNo 9 ☐ Unknown	9□ Unknown		Ginor (apcom)				
<u>α</u>	that the de led by the a detached f		Part II. Other significant conditions of	ontributing to death b	ut not resulting in the	underlying cause	e given in Part I.	23e. Did	tobacco use contri	ribute to the cause of death?
Records,	signed d be de	d by	ATRIAL FIBRIL	LATION				10	Yes 2 No	3 ☐ Probably 4 ☐Unknown
Ö	w requir been si should	Completed						24a. Wa	e an 24b W	Vere autopsy findings available
3e	e lav	m						auto	opsy promed? de	rior to completion of cause of leath?
								1 ☐ Yes	-	Yes 2 No
Vital	Physician: this certific ral director,	Be	25. Was case referred to medical examiner?	Hospital:			Other	eath (Check only		
	Phys this al dii	2	1 ☐ Yes 2 No 27. Manner of Death	28a. Date of Inju			4 □ Nursing		how injury occurre	
n	ling I After funer	loi	1 Natural 5 ☐ Pending	(Month, Da	y Year) Injury		Work? 1 ☐ Yes 2 ☐ No	204. 20301100	now injury docume	
is:	Attending r death. actor: Afte	cal	2 Accident investigatio 3 Suicide 6 Could not b	e 29a Place of Ini	ury - At home, farm,			28f. Location	(Street and Number	er or Rural Route Number,
Division of	al or Attending Phys s after death. al Diractor: After this ed in by the funeral di	Certification:	4 Homicide determined		c. (Specity)	otroot, radiory, or		City or To	wn, State)	
_	To the Hospital or Atteni within 24 hours after deatl To the Funeral Diractor: completely filled in by the		29a. Certifier 1⊠ Certifying Pt	nysician: To the best	of my knowledge de	ath occurred at th	ne time, date and plac	ce, and due to the	a cause(s) and mar	nner as stated
	Hos 24 h Fun Fun	Medicai			f examination and/or					and due to the cause(s)
	To the within 2 To the F	Z e	29b. Signature and title of certifier			29c. Li	cense number		29d. Date signed	i (Month, Day, Year)
	⊢≮⊢ŏ		Dans.	m.D.		D	0058392	2	Novembe	ER 3, 2004
	1		30. Name and address of person who		leath (Item 23a) (Tvn				11010111101	40 7 , 2007
	6			CALITAN	UNION YO		106 BOW S	CTASST	ELKTUN.	, MD 2 1921
	St	ate	31. Date filed (Month, Day, Year)	32. Registr	ar's Signature	61	100 1,000	-(,-60-()		(2)
	Regist		NOV - 4 2004	Deve	De Marie					

Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2004 36582 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Death **Physician** Month Traci Neka Diggs 7,2004 <u>October</u> /Medical 2145 4e Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Sinai Hospital Baltimore City

| Worder 24 Hrs. | 8. Date of Birth (Month, Day, Yeer) 5. Social Security Number If Under 1 Year 6. Sex 7. Age (In vrs. lest birthdey) Birthplace (State or Foreign
Country) **Funeral** Days 1 □ M 2 💢 F Months Yrs. Director October 7,2004 Maryland Usuel Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 X Yes 2 □ No Funeral Director Marvland Baltimore City 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? δ 4502 West Fernhill Ave. Apt 1 21215 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☑ No If Yes, Give Year or Detes: Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 ☐ Married ò Baltimore, Maryland 21215-0020 1 ☐ Yes 2 🕅 No Specify: Specify: Black ģ 3 ☐ Widowed 4 ☐ Divorced Be Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry el Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Infant Infant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Peges 1 end 2 should be f Depertment of Heelth end Mentel F important: If item 27 is merked of <u>Tracey Mariano Diggs</u> <u>Nneka Mariama Dixon</u> 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 4502 Fernhill Ave Apt 1 Baltimore, MD 21215

ce of Disposition (Name of Date 20c. Location - City or Town, State Nneka Dixon/Mother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition in ury or 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State -8-07 4 ☐ Donation 5 ☑ Other (Specify) Sinai Hospital Baltimore City 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Sinai Hospital 2401 W. Belvedere Ave. Balto. MD 21215 23a. Part f. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset end Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Prematurity Examiner Due to (or as a consequence of): Be Completed by Physiclan/Medical Examiner Chorioamnionitis or Attending Physician: The law requires that the death certificate be executed efter deeth. Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Preterm, premature rupture of membranes Due to (or as a consequence of) Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of deeth? 3 Probably 4 Unknown 1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was en eutopsy performed? 1 ☐ Yes 2 🐼 No 1 ☐ Yes 2 ☑ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 🕅 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 Yes 2 No 2 ER/Outpetient 3 DOA To the Funeral Director: After thi completely filled in by the funeral 27. Menner of Deeth 28a. Date of Injury (Month, Dey Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Netural 2 Accident 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rurel Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours To the Funeral I 1 Cartifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

1 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) 29b. Şignature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) P16529 October 7,2004 30. Name end eddress of person who completed cause of leath (Item 23e) (Type, Print) Heather J. Kipa, MD Sinai Hospital 2401 Belvedere W. Ave. Baltimore, MD 21215 2004 Registrer Signature

DHMH 16 Rev 6/95

Registrar

DHMH 17 Rev 1/2001

DORMAN

				e of Maryland / D	ера		Health and	Mental Hyg		36584
	Physici /Medio Examir	al	Decedent's Name (First, Middle, Last) James Fdward Dicker: 4a. Facility Name (If not institution, give street at			4b. City, Town	or Location of Deat	2. Date of Deal Month October	th Day Year	3. Time of Death 11:21 P M
	Funeral Director	ler	1204 Race Street 5. Social Security Number 402-64-2582 6. Sex	7. Age (In yrs. last birth	hday) 'rs.	Cambrill Under 1 Year Months Day	idge ir If Under 24 Hrs		Dorches	
\sim	ō	tor	Usual Residence of Decedent 10a. State 10b. County MD Dorchester	10c. City, Town	or Lo		mbridge			10d. Inside City Limits 1 XYes 2 □ No
Z	ath with the 23e or 28e	rai Direc	10e. Street and Number 1204 Race Street			10f. Zip Code	21613		0g. Citizen of What C	
036 A	be filed within 72 hours after deeth with the Maryland ital Hyglene. d other than "naturel", or items 23e or 28e-f show event, the Macked Examiner must be notified at	Completed by Funeral Director	1 Never Married 2 Married 1	Decedent Ever in U.S. ed Forces? Yes 2 No is, Give r or Dates: 1969-72		Was Decedent of f Yes, specify Cu 1 ☐ Yes 2 📉 N	Hispanic Origin? (Suban, Mexican, Puerlo Specify:	pecify Yes or No- o Rican, etc.)	14. Race - Am Black, Wh Specify: W	
21215-0036	within 72 ho lene. than "natur the Medical	ompleted	15. Decedent's Education (Specify only highest grade compl Elementary/Secondary (0-12) Coll	eted) ((Give life. I	dent's Usual Occ kind of work don DO NOT use retil	e during most of wor red)	rking	16b. Kind of Business heating &	·
Maryland 2		To Be Co	17. Father's Name (First, Middle, Last) James E. Dickerson				18. Mother's Nar	ne (First, Middle, M ine Fitz:	Maiden Sumame) Simmons	
	1 and 2 sh Health and tem 27 is m		20a. Method of Disposition	prother 20b. Place of	05		Creek Rd.		City or Town, State, Ge MD 2 Coc. Location - City o	
Baltimore,	permit. Pages Department of Importent: If it eny Injury or o		1 Seurial 2 ☐ Cremation 3 ☐ Removal 1 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee	from State	22	Veterans . Name and Add	Cem 11	/3/04 homas Fur	Hurlock, neral Home	MD P.A.
	Physician		23a. Part1. Enter the disease, or complications shock, or heart failure. List only one caus Immediate Cause (Final disease or condition	that caused the death. Do not on each line.					MD 21613 est,	Approximate Interval Between Onset and Death
	/Medical Examiner	Examiner	resulting in death) Sequentially list conditions.	ue to (or as a consequence of						10/25/200
68760,	ficate be executed g physician and as the burial-transit	cai	resulting in death) Last	ue to (or as a consequence of	f):					
P.O. Box	The law requires that the death certificat tile has been signed by the attending phy page 2 should be detached for use as th	Physician/Med	in the past 12 months?	s, outcome of pregnancy Live birth 2 Tetal death Pregnant at time of death Unknown		Ectopic pregnan Other (specify)	су		23d. Date of de Month	olivery Day Year
	w requires that been signed b should be deta	þ	Part II. Other significant conditions contributing	to death but not resulting in	the ur	nderlying cause g	given in Part I.	23e. Did tob	oacco use contribute t	o the cause of death?
Vital Records,		Completed	25. Was case referred to medical				00 Bloom of Dog		prior to death?	utopsy findings available completion of cause of s 2 No
o	ding Phys	ation; To Be	examiner? 1 Yes 2 No Hospital:	1 Inpatient 2 ER/Outs Date of Injury (Month, Day Year) 28b. Till Inj		28c. Inj	ther: 4 🗆 Nursing H	-	nce 6 Other (Spe w injury occurred	acify)
Division	oitel or Attendurs after deathurs after deathurel Director:	Certification:	4 Homicide	Place of Injury - At home, fare building, etc. (Specify)				City or Town		
	To the Hospitel or At within 24 hours after or To the Funerel Direct completely filled in by	Medical	(Check only 2 Medical Examinar: On	To the best of my knowledge, the basis of examination and manner stated.	death Vor inv	estigation, in my	time, date and place opinion, death occu nse number	rred at the time, da	ate and place, and duraged. Date signed (Man.	e to the cause(s)
	F 3 F 8		muchael de	cause of death (Item 23a) (T	Type	DG Print)	12005		11/1/0	4
	Sta	ate	Michael Lees 31. Date filed (Month, Day, Year)	830 Chee 32. Registar's Signature	30	peak	e Dr, C	Cambi	rage 1	1021613
	Regist	_	NOV 0 3 200	Sien &	5	book				

State of Maryland / Department of Health and Mental Hygie () [] [RICHARD DAVID DEAN

36585

	IO DITT		For Stete Registrar		Cei	tificate of	Death	Reg.	LUU₩ No.	30303
			1. Decedent's Name (First, Middle, La	st)				2. Date of Death	DayYea	3. Time of Death
	Physicia /Medic		Richard	David De	ean			OCT. 3	9°, 2004°	9:50 Р м
	Examin		4a. Facility Name (If not institution, giv				r Location of Death		4c. County of Do	GEORGES
			FORT WASHINGTON		to the first section of the contract of the co	FURT WA	SHINGTON If Under 24 Hrs.	O Data of Righ		
	Funeral		5. Social Security Number 6. S	Sex 7. Age (/	n yrs. last birthday) 32 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, Ye Oct 14,	ear)	Birthplace (State or Foreigr Country) AShington DC
	Director	-	220 17 1145 Usual Residence of Decedent	ΛΛ				000 14,	1772 110	ishiring con be
	yland		10a. State 10b. County	11	0c. City, Town or Lo	cation				10d. Inside City Limits
	Mar.	ģ	Maryland Charle	s	Indian	Head				1 □ Yes 2 □ No
	or 28.	Director	10e. Street and Number			10f. Zip Code		10g.	Citizen of What	
	th will	<u>a</u>	15 Jamison C	ourt			0640		United	
	tems	ne	11. Marital Status	12. Was Decedent Eve Armed Forces?	er in U.S. 13.	Was Decedent of H If Yes, specify Cubi	lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - A Black, W	merican Indian, hite, etc.
36	within 72 hours after death with the Maryland ene. than "natural", or Items 23a or 28a-f show than "natural", or Items to Medical Examinat must be neitified at	by Funeral	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☐ Your Sire Year or Dates:		1□ Yes 2□ No	Specify:		Specify:	Black
Maryland 21215-0036	tural		15. Decedent's E		16a. Dece	dent's Usual Occup	pation	16	b. Kind of Busine	
75	nin 72 n "ne	Completed	(Specify only highest gr Elementary/Secondary (0-12)	ade completed) College (1-4or 5+)	(Give	kind of work done DO NOT use retire	during most of work d)	ing	DET Dro	*****
212	d with giene grene er tha	mo	12	Consign (1 40.07)	Sewe	r Line Te	T		REI Dra	yco
pu	be filed htal Hygie ed other event, II	Be	17. Father's Name (First, Middle, Las		_			e (First, Middle, Mai		
ylai	Ment Ment arked arice	일		ward Dean,				on D. Proc		
lar	s 1 and 2 should be filed within 72 hours after death with the Marylan if Health and Mental Hygiene. Item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, If a Medical Examiner must be notified at		19a. Informant's Name/Relationship		1			al Route Number, C		e, Zip Code) , MD 20744
	tealth im 27 her tr		Sharon D. Procto	r (Mother)					c. Location - City	
100	or off		1 X Burial 2 ☐ Cremation 3				ce) Nov 5,			
Baltimore,	it. Partmer rtmer rtant: njury		* 4 □ Donation 5 □ Other (Spec 21. Signature of Funeral Service Lice		Resurrec					Maryland nc. 6633 01d
Bal	permit. Pages 'Department of Himportant: If ite any injury or of any injury or of		21. Signature of Purietal Service City	11/20128				, Clinton		
			23a. Part 1. Enter the disease, or cor	nplications that caused th	ne death. Do not en			·		Approximate Interval Between
	Dhysisian		shock, or heart failure. List only Immediate Cause (Final	one cause on each line.						Onset and Death
	Physician /Medical		disease or condition resulting in death)	a. Due to (or as a	consequence of):	Jucies				
	Examiner									
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a	consequence of):					
	ocuted ind transi	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c	-0					
ő,	e exe dan a urial-		resulting in death) cast	Due to (or as a	consequence of):					
68760,	ficate be executed physician and is the burial-transit	Medical	•	d						
9 x	ding p	-	IF FEMALE:	23c. If yes, outcome of	pregnancy				23d. Date of	delivery
Box	eath cer attendin for use	lan	23b. Was decedent pregnant in the past 12 months?	1 Live birth 2 4 Pregnant at ti	Fetal death 3	☐Ectopic pregnand ☐ Other (specify) _	у		Month	Day Year
Ö	the d	Physician	1 □ Yes 2 □ No 9 □ Unknown	9□Unknown						
٦	The law requires that the death certificate be executed ite has been signed by the attending physician and page 2 should be detached for use as the burial-transit		Part II. Other significant conditions	contributing to death but	not resulting in the	underlying cause gr	ven in Part I.	23e. Did toba	cco use contribut	e to the cause of death?
rds,	quires n sign	ed by						1 ☐ Yes	2 DX10 3 D	Probably 4 Unknown
00	aw requir as been si 2 should	plet						24a. Was an autopsy	24b. Were	autopsy findings available to completion of cause of
Re	The lav te has	Completed						performe	d? deat	> ?
of Vital Record	Iclan: Th certificate rector, pag	O	25. Was case referred to medical examiner?				26. Place of Dea	th (Check only one)		
f V	Physician: r this certific ral director,	To B	1 XYes 2 No	Hospital: 1 Inpatient		IN SELECT		ome 5 Resident		Specify)
	Jing PI n. After th funeral		27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day	Year) 28b. Time	Wo	ork?	28d. Describe how		toragele
sio	Attending ir death. ector: Afte by the fune	catl	2 Accident investigat 3 Suicide 6 Could not	he J	04 9:1	U	Yes 2 XNo	28f, Location (Stre	tin Co	r Rural Rojnje Numbjer,
Division	or Attencafter death	Certification:	4 Homicide determine		y - At home, farm, s (Specify)	COOL		Keir of Town	299 50W	hat the cine
	pital ours a eral E		29a. Certifier 1 ☐ Certifying	Physicien: To the best of	my knowledge dea	th occurred at the t	ime, date and place		se(s) and marine	
	24 hos Fun etely i	edical	(Check only one) Medicel Ex	aminer: On the basis of e	examination and/or i	nvestigation, in my	opinion, death occu	rred at the time, date	e and place, and	due to the cause(s)
	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Me	29b. Signature and title of certifier) 0/	20		se number		d. Date signed (M	
	F \$ F 3		1 1 - (1 - tal	Ust w	0	.C.M.E		NOV. 1 ,	2004
(30. Name and address of person wh	o completed cause of per	eth (Item 23a) (Type	e, Print)				001
	NB4		PATRICIA A	CON, CA - 1	1111 Pe	enn Stree	t, Baltim	ore, Mary	Land 212	201
		ate	31. Date filed (Month, Day, Year) NOV 03	2004 32. Registrar						
	Regist	rar	110 1 0 0	E007	25 /					

State of Maryland / Department of Health and Mental Hygiene. State Registra Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) Month Day **Physician** Sr. Charles Frederick Evans NOVEMBER 10. 2004 08:06 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** Memorial Hospital CUMBERLAND ALLEGANY If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth Month, Day, Year) Aug 13, 1938 5. Social Security Number 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) **Funeral** 1**X** M 2□ F Wib Yrs. 220-38-0068 66 Director Usual Residence of Decedent the Maryland 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits 28a-f show the Medical Examiner must be notified at Cumberland MD Allegany 1X Yes 2 No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code or items 23a or 21502 USA 25 N. Waverly Terrace Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify Specify: white þ 3 ☐ Widowed 4 ☐ Divorced "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Importent: If tem 27 is marked other than "ne any injury or other traumatic even" Elementary/Secondary (0-12) College (1-4or 5+) Assembly Packer PPG Industries 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be (Oliver M. Evans Edna (Stewart) Evans 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 25 N. Waverly Terrace wife Geraldine Evans 20b. Place of Disposition (Name of cemetery, crematory or other p 20a. Method of Disposition
1 ☑Burial 2 ☐Cremation 3 ☐Removal from State 20c. Location - City or Town, State Davis Memorial Cemetery 11/13/2004 Cumberland MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Namscarpelli Puneral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Infarction **Physician** Myocard days /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner LUVISION OF VITAL RECORDS, P.O. BOX 68760, C. To the Hospitel or Attending Physician: The law requires that the death certificate be executed within 24 hours after Annie. burial-transit Due to (or as a consequence of): P.O. Box 68760, Completed by Physician/Medical the as esn 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy signed by the atter in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 1 Yes 2 No of Vital Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 28a. Date of Injury (Month, Day Year) After thi 28c. Injury at Work? 27 Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending 1 Natural 1 ☐ Yes 2 ☐ No death. Accident investigation 6 Could not be determined 28e. Place of Injury - At home, larm, street, lactory, office building of (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 4 Thomicide within 24 hours a To the Funerel I 1St Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier , 2004 NOVEMBER / D36766 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 924 Seton Drive Cumberland, Maryland 21502 Vik Poonai M.D. 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar NOV 1 8 2004 DHMH 17 Rev 1/2001

ORIGINAL

STEPHEN UPSHUR ELMORE unknown 04-353 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2004 04-6961 DOS 36587 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Year STEPHEN October 27, 2004 2105 p /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 11689 Somerset Avenue Apt. 2 Princess Anne Somerset 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1**⊠**M 2□F Director 213-98-20+2 Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location r than "natural", or Items 23a or 28a-f show the Medical Exactl at must be notified at 10d. Inside City Limits 1 Yes 2 No ALISBUR Directo WICDMICO MD 10e. Street and Number 10g. Citizen of What Country? 3885 804 death v KES 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Importent: If Item 27 is marked other than "natural", or Ite any injury or other treumatic event. It is Medical Ferrit 1 Yes 2 No If Yes, Give Year or Dates: Never Married 2☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No þ Specify: BLACK 3 ☐ Widowed 4 ☐ Divorced Specify: Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) EPSI PERATOK 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) STEPHEN ELMORE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City of Town, State, Zip Code) 3885-B. MAJETTE-MOTHER SAUS RURY MS 21804 20c. Location - City or Town, State ST LUKESKD. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1 Burial 2 4 □ Donation Cremation 3 □Removal from State 3 FRUITIAND. 5 Other (Specify) 0 MD 21. Signalura neral Service Licensee 22. Name and Address of Facility LISABELLA ST. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or healthailure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a.

Charlet would for her death. Approximate Interval Between Onset and Death **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed the burial-transit and Due to (or as a consequence of) Box 68760 the attending physician Physician/Medical use as i IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4☐Pregnant at time of death Day 5 Other (specify) Records, P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 XNo Completed autopsy performed? Yes 2☐No Division of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one. Hospital: Other: 2 1X Yes 2 ☐ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4□ Nursing Home 5□ Residence 6□ Other (Specify) at scene this 27. Manner of Death 28b. Time of 28c. Injury at Work? After Certification: 28d. Describe how injury occurred 5 Pending investigation 1 Natural 10/27/04 2 Accident

To the Hospital or Attending Physicien: death. within 24 hours after death

To the Funeral Director:
completely filled in by the

3 ☐ Probably 4 ☐ Unknown

24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No

Year

unknowa 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Yes 2 No

Subject was she Location (Street and Number or Rural Route Number, City or Town, State) 11649 Srunwflet

29a. Certifier (Check only one)

3 Suicide

4 Homicide

Residence

Sommerset Are Anne Princess 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

OCME

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201

October 28, 2004

Zefli Mil 31. Date filed (Month, Day, Year) State

NOV 03 2004

6 Could not be

32. Registrar's Signature

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Registrar

		•	For State Registrar	,400 1	State of M		d / Depa		t of H	ealth a		-		_	36588
			1. Decedent's Name (First, Mi	ddle, Last)		4						2. Date of De	ath		3. Time of Death
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	Examin		4a. Facility Name (If not institu	-		r)		4b. City,		Location of	of Death		4c. C	County of Deat	h
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		Registrar 1. Decedent's Name (First, Middle, La	ast)		· · · · · · · · · · · · · · · · · · ·		2. Date of Dea	ith		3. Time of Death
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arylar show	-	10a. State 10b. County			ocation					1 ☐ Yes 2 🕅 No
188-f	Director	Maryland Prince (George's	Landover	10f. Zip Code		T	10a Citize	n of What Cou	intry?
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That de p	9		s contributing to death t	out not resulting in the	underlying cause gr	ven in Part I.	23e. Did t	obacco use	a contribute to	the cause of death?
ds quires n sign) d						10'	Yes 2 🛚	No 3□Pro	bably 4 □Unknown
VITAL RECONDS, P. sician: The law requires that certificate has been signed b rector, page 2 should be deta	Completed						24a. Was	an	24b. Were au	topsy findings available ompletion of cause of
He la he la le ha se la la la la la la la la la la la la la	a di						perfo	rmed?	death?	2 No
	0	25. Was case referred to medical				26. Place of Dea				
Of VI Physici this cer al direc	, C	1 ☐ Yes 2X No	Hospital: 1 🛣npati	ent 2 ER/Outpati	ent 3 DOA	ner: 4 🗆 Nursing H	ome 5 Resi	dence 6[□Other (Spec	sity)
1 Of ng Phys ter this neral d	5		28a. Date of Inj (Month, Da	ury 28b. Time ay Year) Injury	/ Wo		28d. Describe	how injury	occurred	
andir sath. or: Af	o the	2 Accident investigat	4 5 4]Yes 2□No	00(1 1: /	0	Marshara	-10-44
Division or Attending after death. Director: Afte	Cortification	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	ad 289. Place of II	ijury - At home, farm, s itc. (Specify)	street, factory, office		City or To	wn, State)	Number or Hu	ral Route Number,
Division of VIta To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: Atter this certific completely filled in by the funeral director,	, lesi		Physician: To the best	of examination and/or	ath occurred at the tinvestigation, in my	me, date and place opinion, death occu	, and due to the irred at the time,	cause(s) a date and p	nd manner as lace, and due	stated. to the cause(s)
the thin 2.	Modical	one) 29b. Signature and title of cedifier	and manner s	tated.	29c. Licen	se number		29d. Date	signed (Month	n, Day, Year)
T W T		X.VI.da	un II	Walsh	3 u/\)	54099		10/	29/20	504
12		30. Name and address of person w	ho completed cause of	death (Item 23a) (Typ						*
	4	Kathy Ann M. Wal		1500 Fore	st Glen R	d., Silve	er Sprin	g, MD	20910	
	State	31. Date filed (Month, Day, Year)	32. Regis	trar's Signature	Span					
neg	istra		100	~	MIRA					

		1	_ Stete	artment of Health and Me rtificate of Death		ene No2004 36591
			Registrar 1. Decedent's Name (First, Middle, Last)		2. Date of Death	3. Time of Death
	Physicia /Medic		Ellen H.N. Fan		October	30, 2004 6:02 A. M
	Examin		a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death
			Casey House	Rockville If Under 1 Year If Under 24 Hrs. g	B. Date of Birth	Montgomery 9. Birthplace (State or Foreign
	Funeral Director	- 1	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, 1 ☐ M 2XI F 60 Yrs.	Months Days Hours Min.	(Month, Day, Y	(ear) Country) China
	ס		Usual Residence of Decedent		20,7 1,7 1	
	arylan show		10a. State 10b. County 10c. City, Town or L Maryland Montgomery Boyds	ocation		10d. Inside City Limits 1 Yes 2 □ No
	the M	ecto	10e. Street and Number	10f. Zip Code	100	g. Citizen of What Country?
	3a or		18405 Bright Plume Terrace	20841		United States
336	permit. Pages 1 and 2 should be tiled within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: if Itam 27 is marked other than "natural", or Items 23a or 28a-1 show amy injury or other traumatic event. Its Medical Example at right or children and once.	by Fun	11. Marital Status 1 □ Never Married 2 ☒ Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ☒ No If Yes, Give Year or Dates:	Was Decedent of Hispanic Origin? (Spec If Yes, specify Cuban, Mexican, Puerto Ri	ify Yes or No- ican, etc.)	14. Race - American Indian, Black, White, etc.
200	72 hor	eted	(Specify only highest grade completed) (Give	dent's Usual Occupation kind of work done during most of working	7 16	6b. Kind of Business/Industry
121	within ene. than "	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	DO NOT use retired) ntist		Doton
d 2	filed v Hygie other t		17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Ma	Botany aiden Sumame)
an	lid be lental rked c	To Be	Shou Kang Fan	Ziy Ying	Tang	
Maryland 21215-0036	and N	-	19a. Informant's Name/Relationship (Type, Print) 19b. Mail 1840	ng Address (Street and Number or Rural 5 Bright Plume Terr	Route Number, (City or Town, State, Zip Code)
	and and marking markin	-	Turig bring bri ilusburia Boyo	s, MD 20841	-	Oc. Location - City or Town, State
Baltimore,	if ita		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Geo. Was	h - UniversityOctobe	er 30 👢	ashington, D.C.
븚	artmer artmer ortant injury		'4 Donation 5 □ Other (Specify) 2. Signature of Funeral Service Licensee			
Ba	Departiment Department		Mutre Xenda	2. Name and Address of Facility Columbia Mortuary S P,.O. Box 58007 Was	Services Shington	, Inc. , D.C. 20037
	Physician /Medical Examiner	Examiner	23a. Part1. Enter the disease, or complications that caused the death. Do not enshock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of Figure 1). Due to (or as a consequence of): Due to (or as a consequence of):	on the mode of dying, each to candidate of		t, Approximate Interval Batween Onset and Death
Box 68760,	death certificate be executed e attending physician and infor use as the burial-transit	dicai	Due to (or as a consequence of): d. IF FEMALE: 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3	□Ectopic pregnancy		23d. Date of delivery
o.	res that the deat signed by the att be detached for	Physician/Me		Other (specify)		Month Day Year
rds, P	w requires tha been signed I should be det	þ	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did toba	cco use contribute to the cause of death? 2√ No 3 □ Probably 4 □Unknown
I Records,	The law ate has b page 2 st	Completed			24a. Was an autopsy performe	24b. Were autopsy findings available prior to completion of cause of death? No 1 Yes 2 No
/ita	Physiclan: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner? Hospital:	26. Place of Death		
of Vital	Phys this ral di	. To	T Tes 2X No T Inpatient 2 EH/Outpatie	int 3 DOA 4 Nursing Horn	e 5 Residen	TIOSPICE
O	Attanding Ph r death. ector; After th by the funeral	tion	27. Manner of Death 1 \int \text{Natura} \text{ 5 \interpretation} Pending investigation 28a. Date of Injury (Month, Day Year) 28b. Time Injury 28b. Time Inju	of 28c. Injury at Work? M 1 Yes 2 No		
Division	il or Attandii after death. Director: A in by the fu	Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)	treet, factory, office	Bf. Location (Stre City or Town,	et and Number or Rural Route Number, State)
	To the Hospital or Attandi within 24 hours after death. To the Funeral Director; A completely filled in by the fu	edical C	29a. Certifier (Check only one) Certifying Physicien: To the best of my knowledge, deal (Check only one) Certifying Physicien: To the best of my knowledge, deal (Check only one) Medicel Exeminer: On the basis of examination and/or and manner stated.			
		Me	29b. Signature and title of certifier	29c. License number D35635		d. Date signed (Month, Day, Year) Stober 30, 2004
	3		30. Name and address of person who completed cause of death (Item 23a) (Type	, Print)		
				Muncaster Mill Road	, Rockvi	ille, MD 20855
	Sta Regist		31. Date filed (Month, Day, Year) NOV 0 3 2004 32. Registrar's Signature	Sports		

36592 State of Maryland / Department of Health and Mental Hygie [9] [] [4] 1- State Registrar AMEND #4c PER FH CCHD 11/10/04 DB Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** October 30, 2004 Molly Grant Mary 3:25AM /Medical 4c. County of DeattPRINCE GEORGES 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Prince Frederick Clinton Bradford Oaks Nursing Home If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 1 ☐ M 2 ☐ F Funeral 249 09 7270 84 Yrs. Director Dec 17, 1919 | South Carolina Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits itam 27 is marked other than "natural", or Itams 23a or 28a-f show other traumatic event, the Modical Examiner must be notified at 1 ☐ Yes XX No Director Maryland | Prince George's Aquasco 10g. Citizen of What Country? 10e Street and Number 10f. Zip Code With U.S.A. 20608 17420 Aquasco Farm Road Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status within 72 hours after 1 Never Married 2 Married ☐Yes 2 f Yes, Give 2 No White 1 ☐ Yes 2 ☐ No Baltimore, Maryland 21215-0036 Specify: à 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry d 2 should be filed within : th and Mental Hygiene. 7 is marked other than "r Elementary/Secondary (0-12) College (1-4or 5+) Home Homemaker 6th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Molly (unknown) John (unknown) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 st Department of Health and Important: If itam 27 ia n any injury or other traun <u>once.</u> Robert E. Grant, Sr. (Son) 17420 Aquasco Farm Road Aquasco, Maryland 20608 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Nov 1, 2004 * 4 ☐ Donation 5 ☐ Other (Specify) Clinton, Maryland Lee Crematory 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Lee Funeral Home, Inc. 110 B40 6633 Old Alexandria Ferry RD Clinton, MD 20735 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** YEARS. a MULTIINFARCTION DEMENTIA /Medical Due to (or as a consequence of) Examiner b CHRONIC OBSTRUCTIVE PULMONARY DISEASE. YEARS. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner use as the burial-transit The law requires that the death certificate be executed **YEARS** DEFORMED RHEUMATOID ARTHRITIS attending physician Division of Vital Records, P.O. Box 68760, Physician/Medicai SEVERE ATHEROSCLEROTIC CARDIOVASCULAR DISEASE. YEARS IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy Month Day Year ò in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) the detached 9 Unknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 A Unknown Completed CHRONIC ANEMIA FROM THE ARTHRITIS. 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? page 2 s certificate has autopsy performed? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☑ No fo the Hospital or Attending Physician: funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 🗌 Yes 2 No this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: 1 X Natural 5 Pending investigation er death. rector: A 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide n 24 hours aft ta Funeral Di letely filled in 29a. Certifier 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To tha 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D0012884 NOV.1 2004 myyns n who completed cause of death (Item 23a) (Type, Print) 30. Name and address of pers 7900 Old Branch Avenue #101 Clinton, Maryland 20735 Peter W. Yim M.D.

State
Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

NOV 0 3 2004

gistrar's Signature

		-	For State Registrar Amend #19b PE	State o	f Marylan 11/8/04 . HOME CCE	d / Depa DB Cer	rtmen tificate	of H	ealth a Death	ind M		g. No.	04	36593
	Physicia		1. Decedent's Name (First, Middle, La Grace B. Gree								2. Date of Deat Month Oct 29,	1004	Year	3. Time of Death 11:00 A.M
	/Medic Examin		4a. Fecility Name (If not institution, giv	e street and nu	mber)				Location o			4c. County		•
		¥.	Clinton Nursin 5. Social Security Number 6.5		7. Age (in yrs.	last birthdav)	C.L.	into: 1 Year		24 Hrs.	8. Date of Birth	1		eorge 'S
	Funeral Director			M 21√2XF	103		Months	Days	Hours	Min.	Jan 10	1901	Kans	sas
	and w		Usual Residence of Decedent 10a. State 10b. County		10c. Cit	y, Town or Lo	cation						1	0d. Inside City Limits
	Maryl	ctor	Maryland Prince	George	C1:	inton								1 ☐ Yes 2 ☐ No
	with the	Directo	10e. Street and Number 9211 Stuart	Lana			10f. Zip		20735		1	0g. Citizen of \ Unit	what Cour ed St	
	death v	Funeral	11. Marital Status		edent Ever in U.	.S. 13.	Was Dece				ecify Yes or No- Rican, etc.)	14. Rac	ce - Americ	can Indian,
36	s after , or Ita	by Fur	1 ☐ Never Married 2 ☐ Married 3 € Widowed 4 ☐ Divorced	1 □X/Yes If Yes, G	2 No		1 🔲 Yes		Specify:	, r gorto	Thous, oto.,		y: Whi	
Ö	filed within 72 hours after death with the Maryland Hygiene. other than "netural; or Itams 23e or 28e-f show ent, the Medical Examinar must be molified at	ted b	15. Decedent's E	Year or I		16a. Dece	dent's Usua	al Occupa	ation during most	nf work	ina	16b. Kind of B	usiness/In	dustry
1215	Aithin 7 ne. han "n	mpie	(Specify only highest gr Elementary/Secondary (0-12)	College (life.	DO NOT u:	se retirea	fe Se			Federa	1 Gov	vernment
Maryland 21215-0036	filed w Hygie othar tl ent. In	Be Compieted	17. Father's Name (First, Middle, Las	")					18. Mothe	r's Nam	e (First, Middle, I	Maiden Suman		
ylan	ould be Mental arked atic ev	ToB	Thomas Marchi								Whiteha		0 7	0.40
Mar	perrit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked othar than "netural; or Items 23a or 28e-f show may injury or othar traumatic event, the Medical Examinar must be notified at once.		19a. Informant's Name/Relationship David C. Green	(Type, Print) (SON)		19b. Maili 12 28	ng Address 5 Alln 98 Na	utt C	ourt A	pt 41	1 Prince	Frederic Washi	ck, MD	20678 1, DC 20020
ore,	of Heal		20a. Method of Disposition 1 X Burial 2 □ Cremation 3	Removal from	20b. F	 Place of Dispo cemetery, crea						20c. Location		
Baltimore,	Page tment tant: If		'4 □ Donation 5/ Other (Spec	(y) /	Ce						2004			
Ba	Depri		21. Signature of theral Service	1	362						Funeral			
	Physician	0 1	23a. Part1. Enter the disease, or cor shock, or heart failure. List or Immediate Cause (Final disease or condition resulting in death)	lications that	caused the deat						-			Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in deality	©ue t∜	(or as a consec	quence of):	56	7						100
	ecuted and -transit	Examiner	Sequentially list conditions, if any, reacting to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to	o (or as a consec	anst	id	m	any	5_				27
68760,	ificate be executed g physician and as the burial-transit	icai		d							-			
.O. Box	that the death certifical ted by the attending phy detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 🗀 Live	utcome of pregn birth 2 Feta gnant at time of c nown	al death 3[⊒Ectopic p ⊒ Other (s _i		y				ate of deliv	ery Day Year
s, p	requires that the been signed by th	by	Part II. Other significant conditions	contributing to	death but not res	sulting in the u	underlying	ause giv	en in Part I		23e. Did to	/		he cause of death?
I Record	The law ate has page 2.5	Completed									24a. Was a autop perfor 1 ☐ Yes	an 24b. sy meg? 2 No	Were auto prior to co death? 1 Yes	opsy findings available ompletion of cause of
Vital	Physician: The this certificate ral director, page	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital:	Inpatient 2	TER/Outpatie	nt 3⊡ D	Cth			th <i>(Check only or</i>	1 1000	her (Speci	fv)
of	ng ftei	1	27. Man er of Death 1 Natural 5 Pending 2 Accident investigat	28a. Dat (Mo	e of Injury onth, Day Year)	28b. Time of Injury		28c. Injui Woi	ry at		28d. Describe h			
Division	- e := c	Certification:	3 ☐ Suicide 6 ☐ Could not determine	d 286. Pla	ce of Injury - At t ding, etc. (Speci	nome, farm, si ify)	treet, factor	y, office			28f. Location (S City or Tow		ber or Rur	al Route Number,
	To tha Hospital or within 24 hours at To tha Funaral D completely filled in	edicai ((Check only 2 Medical Ex	aminer: On the	he best of my kn basis of examin inner stated.	owledge, dea ation and/or i	nvestigation	n, in my o	opinion, dea	nd place ath occu	, and due to the c rred at the time, c	date and place	, and due t	to the cause(s)
)	To the within To the comp	W	29b. Signature and title of centiler	1	~~			c. Licens	- 2 Y	53	55	29d. Date signo		
(NR3		30. Name and address of person what Laxmi Berwa, M.	o completed ca	use of death (Ite	m 23a) (Type anch Ar	, Print) ve. #0	C101	, CLi	nton	, MD 207	'35		
	Si Regis	tate trar	31. Date filed (Month, Day, Year)	32.	Redistrar's Sign	nature.	-							

DHMH 17 Rev 1/2001

Registrar

State of Maryland / Department of Health and Mental Hygien 36595 Certificate of Death Rea. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) ^{Day} 2004 Month **Physician** 11:30 a [™] Nov. SARAH E. /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Montgomery Washington Adventist Hospital Takoma Park If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) NOV • 1 • 1911 9. Birthplace (State or Foreign **Funeral** Days Hours 579-16-3961a 1 ☐ M 2 🛛 F Yrs. 93 Wash.D.C. Director Usual Residence of Decedent death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County Item 27 is marked other than "natural", or Items 23a or 28a-1 show other traumatic event, the Modical Examiner must be notified at X□Yes 2□No Director Montgomery Silver Spring MD 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number 12325 NEw Hampshire Avenue 20904 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Importent: If Item 27 is marked other than "natural", or Item any injury or other traumatic event, the Medical Examinations. 1 ☐ Yes 21 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: ģ 3X Widowed 4 □ Divorced Black Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Maintenance/Housekeeper Domestic 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be John Henry Josephine Unk. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3215 11th St.N.W.Washington, D.C. 20010 Brother Charles E.Boyd 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ♥ Burial 2 Cremation 3 Removal from State MD. Nat'l Mem.Park Nov.5,04 Laurel, MD. 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Hunt Funeral Home 21. Signature of Funeral Service Licensee Trancio 908 Kennedy St.N.W.Wash.D.C.20011 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death SEPSIS SYNROME Immediate Cause (Final disease or condition resulting in death) Physician /Medical ASPIRATION PNEUMONTA Examiner S- uentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examine inding physician and use as the burial-transit The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy atter for u in the past 12 months? Month Year Day 4 Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by VRINALY TRACT INFECTION. ACUTE RENDAL FAILURE 1 Yes No 3 Probably 4 Unknown WITH ACIDOSIS HUPERIENSION, DEMENTA 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an s certificate has t autopsy 1 ☐ Yes 2 ☐ No To the Hospitel or Attending Physicien: within 24 hours after death.

To the Funeral Director: After this certifica Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 28a. Date of Injury (Month, Day Year) Director: After th 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 ☐ Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide Varifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier NOVEMBER 1ST, 2004 D 53367 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) (ATTHENSING, MD: 2087) 10810 DARMESTOWN RUAD, SVITE: 202, CATTHENSINGS, MD: 2087) 31. Date filed (Month, Day, Year) State NOV 0 4 2004 Registrar

		1 - For State Registrar	State of Marylan	•	artment rtificate				Reg. No.	004	36596
Physic /Medi	cal	Decedent's Name (First, Middle, Last) Effie Mae Green 4a. Facility Name (If not institution, give s	n		4h City T	TOWN OF	Location of Death	2. Date of Dea Month November	er 1,	2004 unty of Death	3. Time of Death 6:05 P.M
Examir Funeral Director	ner	St. Thomas More I 5. Social Security Number 6. Sex 579-26-6420	Nursing & Reh		• Hy	yatt:	SVILLE If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da) 12/19/	Prin	9. Birthp	lace (State or Foreign
e Maryland e-f show	ctor	Usual Residence of Decedent 10a. State 10b. County D.C.		y, Town or Lo Jashing		-				1	0d. Inside City Limits 1 ☑Yes 2 ☐ No
th with th	al Dire	100. Street and Number 1508 Olive St., N	.E.		10f. Zip (Code	20019		_	of What Cour , S.A.	ntry?
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: if item 27 is marked other then "netural", or items 23a or 28e-f show any injury or other treumatic event, the Medical Exams or must be motified at any injury or other treumatic event, the Medical Exams or must be motified at any once.	by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:		Was Decede If Yes, speci 1 ☐ Yes 2		spanic Origin? (Spi , Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)		Race - Americ Black, White A ecity: A	an Indian, atc. frican— merican
21215-0U36 21215-0U36 3d within 72 hours aff giane "netural", or er the Medical Exam.	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12) 12th		(Give	dent's Usual kind of work DO NOT use	k done di e retired)	uring most of work	ing		of Business/Ind	dustry
Maryland 2 nd 2 should be filed th and Mental Hyg 27 Is marked othe rtreumatic event,	To Be C	17. Father's Name (First, Middle, Last) Jesse Smith					18. Mother's Name Lillia	o (First, Middle, n Jones	Maiden Sui	mame)	
other treum		19a. Informant's Name/Relationship (Ty. Essie E. Booker/Au 20a. Method of Disposition	int		Oliv	e St	nd Number or Rura		ton, I		019
Baltimore, bermit. Pages 1 a Department of He∉ Importent: If item any injury or othe once.		12 Burial 2 □ Cremation 3 □ R '4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service License	Mar	ryland	Nat'l	. Me	em. Pk. 1 s of Facility & S lgton & S			el, Md.	
Danes permi		23a. Part1. Enfer the disease, or complishock, or heart failure. List only or Immediate Cause (Final	ne cause on each line.	th. Do not ent	925 Bu er the mode	rrou of dying	ghs Ave.	N.E., War	ash.,I		Approximate Interval Between Onset and Death
8760, ate be executed XII This is a second XII This burial transit the burial transit the second XII This is a sec	dical Examiner	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of the consequence of t	nuence of): A-A nce of): De p	heros	cher	otic Dial	Orseas iseas	ae Melli		
, F.O. BOX 68 that the death certifical set by the attending ph detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of pregna 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of c 9 □ Unknown	aldeath 3□	Ectopic pre Other (spe				23d	. Date of delive Month	ory Day Year
ecords, P.O law requires that the as been signed by th	þ	Part II. Other significant conditions cor	ntributing to death but not res	sulting in the u	nderlying ca	use give	n in Part I.				ne cause of death?
The The ate h	Completed									prior to con death?	psy findings available inpletion of cause of
DIVISION Of VITAI TO the Hospitel or Attending Physicien: I within 24 hours after death. To the Funerel Director: After this certificat completely filled in by the funeral director, p	tlon: To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigation	Hospital: 1 Inpatient 2 28a. Date of Injury (Month, Day Year)	EP/Outpatier 28b. Time o Injury		Bc. Injury Work	4 Estatisting 110		lence 6 🗆		<i>(</i>)
DIVISI	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At h building, etc. (Special	ome, farm, str fy)	reet, factory,	office		28f. Location (S City or Тои		umber or Rura	l Route Number,
the Hospitel in 24 hours a the Funerel in the Funerel in mpletely filled	edical	(Check only 2 Medical Exemi	sician: To the best of my knowner: On the basis of examination and manner stated.	owledge, death ation and/or in	vestigation,	in my op	inion, death occurr	and due to the deed at the time, d	cause(s) and date and pla	d manner as st ice, and due to	ated. the cause(s)
Toth	M	29b. Signature and title of certifier	antez, m	0		License	51122		4	igned (Month, 3	Day, Year)
1586		30. Name and address of person who co Juanitez Esmeran				, N. E	E., # 008	, Washi	ngton,	D.C.20	017
St Regist	ate trar	NOV 0 5 2004	32. Registrar's Sign	ature							

			1 - State Registrer	State of Maryland	d / Depa	rtment of H	ealth and M Death		gie <u>2</u> e () () (; Reg. No.	36597
	Physici /Media		Decedent's Name (First, Middle, Last, ALICE	М.	GRAY			2. Date of Dea Month OCTOBE	Day Year	3. Time of Death 0951 M
	Examir	er	4a. Facility Name (If not institution, give 7524 Lemon Tree C	ourt	la ad historia (a.)	4b. City, Town, or Hanov If Under 1 Year	Location of Death er If Under 24 Hrs.	0.0	4c. County of Dea	Arunde
	Funeral Director		5. Social Security Number 6. Sec. 578–52–2959 Usual Residence of Decedent	7. Age (In yrs. I	Yrs.	Months Days	Hours Min	Month, Day Decembe	1938 9. Bir (, Year) r 24 Was	rthplace (State or Foreign ountry) hington, DC
	Maryland	ctor	10a. State 10b. County MD Anne Arun		, Town or Lo					10d. Inside City Limits 1X Yes 2 □ No
	th with the 23a or 28	al Dire	10e. Street and Number 7524 Lemon Tree	Court		10f. Zip Code 2107	6	1	U.S.A.	ountry?
980	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "naturel", or items 23a or 28e-f show any injury or other traumatic event, the Medical Evantral must be notified at once.	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.: Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	_ '	Vas Decedent of Hi Yes, specify Cubar ☐ Yes 2 ☑ No	spanic Origin? (Spanic Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	Black, Whi	
Maryland 21215-0036	within 72 hou sne. than "nature is Medical E	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12) 7th		(Give life. L	ent's Usual Occupa kind of work done of DO NOT use retired, Maker	lurina most of work.	ing	16b. Kind of Business	
land 5	uld be filed v fental Hygie rked other t tic event, th	To Be Co	17. Father's Name (First, Middle, Last) Arthur Cobb Sr.		поше	riakei	18. Mother's Name	e (First, Middle, i Williams	Maiden Sumame)	
lary	2 shou and N is mai		19a. Informant's Name/Relationship (Ty	rpe, Print)	19b. Mailin	g Address (Street a	and Number or Rura	al Route Number	r, City or Town, State,	Zip Code)
Baltimore, N	ages 1 and int of Health t: If item 27 y or other tr	1	Louise Tucker/Dau 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	20b. Pl	lace of Dispo emetery, cren	sition (Name of natory or other place	e)	Date	Maryland 20c. Location - City or	Town, State
Baltir	permit. P Departme Importan any injur		21. Signature of Funeral Service Licens	hall		Name and Addres	s of Facility J	. B. Jei	Londove nkins Fune r, Marylan	ral Home
	Pnysician /Medical		23a. Part1. Enter the disease, or compl shock, or heart failure. List only of immediate Cause (Final disease or condition resulting in death)	a. Arterios	elen		,		•	Approximate Interval Between Onset and Death
68760,	Examiner	cal Examiner	Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of the consequence of t	95 ience of): AGC		litus val f		næ'	
P.O. Box 68	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the buriat-transit	d. IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown						23d. Date of de Month	livery Day Year	
	w requires that been signed b should be deta	by	Part II. Other significant conditions cor	ntributing to death but not resu	ilting in the ur	derlying cause give	n in Part I.	23e. Did tob	pacco use contribute to	o the cause of death?
Il Records,	The law requivate has been page 2 should	Completed						24a. Was a autops perform	prior to	utopsy findings available completion of cause of
Vita	yeicien: The is certificate hadirector, page	o Be	25. Was case referred to medical examiner?	lospital:	-2/2	3□ DOA Othe	26. Place of Death	0.00		
Division of Vital	유무	Comparison Com								cify)
Divis	o in l	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury - At hos building, etc. (Specify	me, farm, stre	et, factory, office		28f. Location (St. City or Town	reet and Number or Ru n, State)	ural Route Number,
	To the Hospitel within 24 hours a To the Funerel I completely filled	Medical	(Check only one) 2 Medical Exami	sician: To the best of my knowner: On the basis of examination and manner stated.	viedge, death ion and/or inv	estigation, in my op	inion, death occurr	ed at the time, da	ate and place, and due	to the cause(s)
	or William	~	29b. Signature and title of certifier	2 Del	outy O	29c. License			9d. Date signed (Monti	
Y	K ()		William P	implered ause of death (Item	mD	_ 69	5 Av	neric	11/3/1 A 21	035
	Sta Registr		31. Date filed (Month, Day, Year) NOV 0 5 2004	Registrar's Signat	ure	K)				

		•	For State Registrar	State of Man		artment of He rtificate of D			2004	36598
	Obvojaje		1. Decedent's Name (First, Middle, Last)					Date of Death Month	Day Yea	3. Time of Death
	Physicia /Medic		Margaret Eleanor	Gabel				November	2, 2004	12:10 ^{a м}
	Examin	er	4a. Facility Name (If not institution, give :	street and number)		4b. City, Town, or I	ocation of Death		4c. County of D	eath
			Montgomery Gener			Olney	# 11 - 3 - 1		Montgo	
	Funeral Director		5. Social Security Number 6. Sec 172-14-5243	7. Age (//	n yrs. last birthday) 82 Yrs.	If Under 1 Year Months Days	Hours Min.	8. Date of Birth (Month, Day,) March 15	^(өаг) , 1922 F	Birthplace (State or Foreign Country) Pennsylvania
	Du News		Usual Residence of Decedent 10a. State 10b. County	1/	0c. City, Town or Lo	antion				Lord Institution
	shore	ō								10d. Inside City Limits 1 ☐ Yes 2₹3*No
	28e-1	ect	Maryland Montgom 10e. Street and Number	ery	Silver S	10f. Zip Code		100	g. Citizen of What	
	with 3e or	٥	2900 N. Leisure W	orld Blyd	#401	20906		105	USA	Country
	ms 2:	era		12. Was Decedent Eve	or in U.S. 13. V	Was Decedent of His	panic Origin? (Spe	cify Yes or No-		merican Indian,
36	perrit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If Item 27 is marked other then "natural", or Items 23e or 28e-f show any injury or other treumatic evant, Itel Medical Evant and interest by indifficial and other.	by Fur	1 ☐ Never Married 2 ☐ Married 3 ※ Widowed 4 ☐ Divorced	Armed Forces? 1½ Yes 2 ☐ No If Yes, Give Year or Dates: W		f Yes, specify Cuban 1 □ Yes 2🏻 No	Specify:	Rican, etc.)	Black, W Specify: W	
2-00	72 hou natura	eted	15. Decedent's Edu (Specify only highest grade	cation	16a. Deced	dent's Usual Occupat kind of work done du	ion iring most of worki	ng 16	Sb. Kind of Busine	ss/Industry
21215-0036	d within giene. ir then	ompl	Elementary/Secondary (0-12)	College (1-4or 5+)		00 NOT use retired) nistrativ	e Assista	ant I	Fire Depa	artment
	e filed al Hyg l otha vant,	3e C	17. Father's Name (First, Middle, Last)			1	8. Mother's Name	(First, Middle, Ma	aiden Sumame)	
<u>Va</u>	Menta Menta arked	To	John Edward Burn	s			Grace E	. Edwards	5	
Maryland	2 sho and Is ma		19a. Informant's Name/Relationship (Ty	•		ng Address (Street ar				a, Zip Code)
	l and lealth im 27 har ti		Paul A. Gabel/ So		107 20b. Place of Dispo	Wilson La				
Baltimore,	Pages 1		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)		cemetery, cren Gate	of Heaven eterv	Nover	mber 5,	c. Location - City	
Balti	permit. DepartmImporte any nju		21. Signature of Funeral Service License	100	Fi	Name and Address		Funeral	Home Inc	
	_	-	23a. Part1. Enter the disease, or complishock, or heart failure. List only of	cations that caused the						ng, MD 20901 Approximate
U	Pnysician :		Immediate Cause (Final	e cause a each line.						Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	Due to (o) as a co	onsequence of):	^				2 vects
B	Examiner		Sequentially list conditions	Smal	1 bow	el Ob	struc	tron		2 werks
	P #	iner	daily, loading to intradiate	Cua to (or as a c	onsequence of):	^		,		
	ecute and trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last		5T	Can ce	·~			2 years
60,	icate be executed physician and s the burial-transit	al E	is sain, and	Due to (or as a co	onsequence of):	Can ce	x G	re/une		2 5000 5
68760,		edical		cong	estive	1100				s jear
Box	ath certi	an/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of p		Ectopic pregnancy			23d. Date of o	delivery Day Year
P.O.	es that the death certifigned by the attending be detached for use a	Physician/M	1 □ Yes 2 □ No 9 □ Unknown	4 ☐ Pregnant at tim 9 ☐ Unknown	e of death 5	Other (specify)			, inchist	Jay 10a
	The law requires that the death cert ate has been signed by the attending page 2 should be detached for use a	by	Part II. Other significant conditions cor	tributing to death but n		nderlying cause given	in Part I.		_ /	to the cause of death? Probably 4 Unknown
COL	w require been si	lete	the or ten	sini			/	24a. Was an	24b Were	autopsy findings available
Division of Vital Records,	: The la cate has page 2	Completed						autopsy performe	prior t	o completion of cause of ?
Zii	certifi	Be	25. Was case referred to medical examiner?	ospital:		Othor	26. Place of Death			
of	Phys ral di	7	1 Yes 2 No	1 Minpatient	2 ER/Outpatient	t 3 DOA		ne 5 Residence 8d. Describe how		pecify)
on	ding th. After	tlon	1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Ye	ear) Injury	Work?	es 2 No	od. Describe flow	injury occurred	
Visi	Attan r dea actor by the	iffica	3 Suicide 6 Could not be determined	28e. Place of Injury	- At home, farm, stre			8f. Location (Street	et and Number or	Rural Route Number,
۵	tal or A	Certification:	4 Hornicide	building, etc. (\$	эрөспу)			City or Town, S	state)	
	To the Hospital or Attanding Physician: The law within 24 hours after death. To the Funaral Diractor: After this certificate has completely filled in by the funeral director, page 2	edical	29a. Certifier 1 Certifying Phys (Check only one)	ician: To the best of mer: On the basis of ex and manner stated	amination and/or inv	occurred at the time restigation, in my opin	, date and place, a nion, death occurre	nd due to the caused at the time, date	se(s) and manner and place, and d	as stated. ue to the cause(s)
	To th withir To th comp	Me	29b. Signature and title of certifier	011		29c. License r		29d	Date signed (Mo.	nth, Day, Year)
	20		1/4 wages	of the Lea	- m		2817	N	Ovembe	12,2004
			30. Name and address of person who co	mpleted cause of death		errint)	fre w	heatan	ans.	20502
	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's	Signature		1			

Mary Gustave 04 AK

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible

State of Maryland / Department of H Certificate of L	lealth and Mental Hygiene	36599
)	2. Date of Death	3. Time of Death

Physicial Decedent's Name (First, Middle, Last) Mary Irene Gustave 4a. Facility Name (In or institution, give street and number) 4b. City, Town, or Location of Death Month November 2, 2004 11: Funeral Director Funeral Direc	Inside City Limits TXXYes 2 □ No Indian, Ty Te) State
Physician Mary Irene Gustave Month Day November 2, 2004 11: Movember 2, 2004 11:	1:41 A M (State or Foreign Vania Inside City Limits 1XXYes 2 □ No Indian, Py State
Redical Facility Ame Facility	o (State or Foreign Vania Inside City Limits 1XXYes 2 □ No ndian, ry fe) 101 State
Funeral Director Parford Memorial Hospital Have de Grace Harford Harford Harford Harford Harford Harford Social Security Number 6. Sex 10 m 2 m 1 m 1 m 1 m 1 m 1 m 1 m 1 m 1 m 1	vania Inside City Limits 1XXY es 2 □ No Indian, India
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Aberdeen, Maryland 21001-3399	
inscribed in the property of t	
	proximate
Immediate Cause (Final All 1995) A Construction Country of the Country of the Country o	erval Between set and Death
/Medical disease or condition resulting in death) Due to (or as a consequence of):	
Examiner	
Due to (or as a consequence of): Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):	
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O at the past 12 months? 1 Ves 2 No 9 Unknown 1 Ves 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause	
1 Yes 2 No 3 Probably 4	
FFEMALE: 23b. Was an autopsy performed; 24a. Was an autopsy performed; 24b. Was an autopsy performed; 25c. If yes, outcome of pregnancy 1	
autopsy performed? 1 Yes 2 No 25. Was case referred to medical examiner? Hospital: Others	4 Kunknown
25. Was case referred to medical 26. Place of Death (Check only one)	4 Kunknown indings available tion of cause of
Hospital: 1 Innation: 3 FR/Outnation: 3 DOA Other: 4 All Murring Home 5 Residence 6 Control Constitution	4 Kunknown indings available tion of cause of
1 Inpatient 2 MER/Outpatient 3 DOA Output 4 Nursing Home 5 Residence 6 Other (Specify)	4 Kunknown indings available tion of cause of
Accident Substitute Subst	4 Kunknown indings available tion of cause of

29a. Certifier (Check only one)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Gertifying Physician: 10 the best of my knowledge, death occurred at the time, vace and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number O.C.M.E. 29d. Date signed (Month, Day, Year) November 4, 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ZABIAC

31. Date filed (Month, Day, Year)

NOV -

gistrar's Signature

111 Penn Street, Baltimore, Maryland 21201

State Registrar

To the Hospitel or Attending Physicien: The law requires that the death certificate

filled in by

within 24 hours after death. To the Funerel Director:

Certification: To

Medical

			For State Registrar	State of M	arylar		artment of rtificate of				giene Reg. No2 () {) <i>[.</i>	36600
	Pĥysici	an	1. Decedent's Name (First, Middle Mary Elizabeth							2. Date of Dea Month	ith Day	Year	3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution PUNINSUID REG		ra i	Ceku	4b. City, Town,	or Location		10	3.7 4c. County (04 of Death .	
	Funeral Director		5. Social Security Number 215-52-1945			last birthday) Yrs.	If Under 1 Yea Months Days		Min.	8. Date of Birth (Month, Day Dec. 31	, Year) , 1914	Coun	ace (State or Foreign try) Sylvania
7	Maryland f ahow	or	Usual Residence of Decedent 10a. State 10b. County Maryland Somer			ty, Town or Lo		-		·		10	Od. Inside City Limits 1 ☐ Yes 2 📉 No
5	th the l or 28a- s rotifi	Funeral Director	Maryland Somer	Sec	111	ncess	10f. Zip Code	Λ			10g. Citizen of W	hat Coun	try?
	s 23a	ral	10572 Anderson	Road 12. Was Decedent	From in 11	C 12	Man Danidan at	21853	i=i=2 (C==	-#- V N-	US	A - America	an Indian
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or Itams 23a or 28a-1 ahow important: If item 27 is marked other than "natural", or Itams 23a or 28a-1 ahow important in item 12 is marked on 28a-1 ahow in injury or other traumatic event, the Medicul Ever's mark must be right of an once.	by	11. Marital Status 1 □XNever Married 2□ Mar 3 □ Widowed 4 □ Divorced	ried Armed Forces? 1 ☐ Yes 2 🛣		i	Was Decedent of If Yes, specify Cu 1 ☐ Yes 2 🛣 No			Rican, etc.)	Specify:	c, White, e	
21215-0036	within 72 ho sne. than "natur	Completed		nt's Education est grade completed) College (1-4or :	5+)	(Give	dent's Usual Occi kind of work don DO NOT use retir	e during mos	st of workin	ng	16b. Kind of Bu		·
	I Hygie othar ant, I	Be Co	17. Father's Name (First, Middle,			Narse		18. Moth	er's Name	(First, Middle,	Maiden Surname		LCII
ylar	ould be Menta arkad atic ev	To B	Hal J. Gintlir	9						ary Law			
Maryland	d 2 shoth and the and the man traum		19a. Informant's Name/Relations Constance Ladd/				ng Address <i>(Stree</i> North Po						i
Baltimore,	ages 1 an ant of Heal it: If itam 2 y or other		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (5	3 □Removal from State	_ ′	Place of Dispo cemetery, crea	osition (Name of matory or other pl	ace)		ate	20c. Location - (City or To	wn, State
Baltir	permit. F Departme Importar any injur		21. Signature of Puneral Service	4 1	be		2. Name and Addi eller Fu 212 Old	ress of Facili	ity		Box 317 Salisbu		D 21802
	Physician	(234. Part1. Enter the disease, o shock, or heart failure. List Immediate Cause (Final disease or condition	only one oduse on each li	the deat	ſ			•				Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as		•							
		Jer	Sequentially list conditions, if any leading to immediate cause. Enter Underlying	b. Due o (or as	a consec		UV.	`					
ó,	cate be executed physician and the burial-transit	l Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as	a conseq		1 stva	etm	Pn	1	Oliver	٠.	
38760,	icate be physic s the bu	dical		d									
P.O. Box 6	law requires that the death certific as been signed by the attending p 2 should be detached for use as I	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Feta	al death 3	Ectopic pregnan Other (specify)	су			23d. Date Mon	of delive	ry Day Year
	res that the de signed by the a be detached f	by Ph	Part II. Other significant conditi	ons contributing to death t	out not res	sulting in the u	nderlying cause g	yven in Part I	l.	23e. Did to	bacco use contri	bute to the	e cause of death?
ords	w require been sig should b		ity for !	mee Contr	à Va	sonh	Din			1 🗆 Y	es 2 No	3 🗌 Proba	ably 4 Unknown
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Vital	Physician: r this certifica ral director,	o Be	25. Was case referred to medica examiner? 1 Yes 2 No	Hospital:	ent 2	ER/Outpatie	nt 3□ DOA O	al		(Check only or ne 5 ☐ Resid	ence 6 ⊡Othe	r (Specify)
ion of	ding h. Afte fune	atlon; T	E [] / 100100111	28a. Date of Inju (Month, Da igation	and the second s	28b. Time o Injury	W		2		ow injury occurre		
Division	in the	Certification;	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide detern	nined 288. Place of in building, et	tc. (Specii	fy)	reet, factory, office			City or Tow			
	Hospital	edical	29a. Certifier 1 Certifyi (Check only 2 Medical	ng Physician: To the best Examiner: On the basis of and manner st	of examina	owledge, deat ation and/or in	h occurred at the vestigation, in my	time, date ar opinion, dea	nd place, a ath occurre	nd due to the c d at the time, d	ause(s) and mar late and place, a	ner as sta nd due to	ated. the cause(s)
)	To the Hospitel within 24 hours a To the Funeral I completely filled	Me	29b. Signature and title of certific			V~	29c. Licer	15/	192	2	29d. Date signed	(Month, E	ey, Mg 218
			30. Name and address of person	who completed cause of c	death (Iter	n 23a) (Type,	Print)			2	~		
	Sta	te	JOSEPH B. 31. Date filed (Month, Day, Year	9 0 200 AP. Regis	ar's Signa	ature 🚣	12. Eas	TEIN .	SHOTE	HRIVE.	JALI	SBLU	ey, MD 218
*,c	Registr		001	A U LUUT	de.	J. J.	Market 1						

GINTLING, SISTER MARY

5/12-27-1645

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 004 36601 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) October 28, 2004 **Physician** 8:30 P M Gray Zella /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Prince Georges Forestville The Millennium of Forestville If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. | Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, **Funeral** 1 ☐ M 2 🗙 F 95 579-32-0296 November 19,1908 Director Washington, DC Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State 28a-f show event, the Medical Exeminer must be notified at 1 XYes 2 No Waldorf Maryland Charles Directo 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code USA 20601 3435 Deertrail Place Items 23a Completed by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status within 72 hours after ☐Yes 2**X** No f Yes, Give 1 Never Married 2 Married ō 1 ☐ Yes ZZNo Specify: Specify: Black If Yes, Givo Year or Dates: 3 Widowed 4 ☐ Divorced natural 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. ant: If itam 27 Is marked othar than Elementary/Secondary (0-12) College (1-4or 5+) Domestic Homemaker 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Wright ပ Arnett Unknown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3435 Deertrail Place Waldorf, Maryland 20601 Hubert Gray / Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 Cremation 3 Removal from State injury or Department
Important: If
any injury of * 4 ☐ Donation 5 ☐ Other (Specify) Resurrection Cemetery 11/2/04 Clinton, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Odessa ales MO1323 Adams Funeral Home P.A. Aquasco, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Congestive **Physician** Hea /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examine physician and the burial-transit pertension Alzheimers Diseasc Physiclan/Medlcai as the attending IF FEMALE: for use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ≦ No Month Day Year 4 Pregnant at time of death 5 Other (specify) ate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 3 ☐ Probably 4 🖼 Inknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2□ No 24a. Was an certificate has autopsy performed? 28 No 1 ☐ Yes funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) examiner Hospital: Other: 4 Mursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred After t 1 X Natural 5 Pending death. investigation 1 ☐ Yes 2 ☐ No 2 Accident the 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide

The law requires that the death certificate be executed Box 68760 P.0. Division of Vital Records, To the Hospital or Attending Physician: within 24 hours after deatl To the Funeral Director: filled in by completely

Maryland 21215-0036

3altimore,

31. Date filed (Month, Day, Year) State

Medical

29a. Certifier

(Check only

29b. Signature and title of certifier

29c. License number D-51520

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year) 10-29-2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

9801 Georgia Avenue Ste.3-41 Silver spring, MD Bahram Pishdad,

NOV 0 3 2004



Registrar

			1 - For State Registrar	State of M		/ Depa		t of H	ealth a	nd Menta		ne 21	04	3660
	Physici /Medi	al	1. Decedent's Name (First, Middle,	Go	Idria	4				Octo	of Death th ober 2	Day 29, 20		3. Time of Death 10:15 A M
	Examir Funeral Director	ier	4a. Facility Name (If not institution, ST. Mary s Nurs 5. Social Security Number 214-30-1283	ing Center	ge (In yrs. las	st birthday) Yrs.	-	nard	Location of LOWN If Under 2 Hours		of Birth oth, Day, Ye	4c. County St. M. 1930	9. Birthp	lace (State or Foreign rland
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or flems 23s or 28s-1 show any injury or other traumatic event. If a Medical Event are must be notified at 90c.	To Be Compieted by Funeral Director	Usual Residence of Decedent 10a. State 10b. County Maryland St. Mar 10e. Street and Number 45999 Great Mill 11. Marital Status 1 Never Married 15. Decedent's (Specify only highest Elementary/Secondary (0·12) 12 17. Father's Name (First, Middle, La Sam Goldr 19a. Informant's Name/Relationship Barbara Goldring 20a. Method of Disposition 1 XBurial 2 Cremation 1 XBurial 2 Cremation 3 4 Donation 5 Other (Specify Control of	s Court Apt 12. Was Decedent Amed Forces: 1	Lexin 312A Ever in U.S. No 5+) 5 phter 20b. Placer	16a. Deceding Cive (Give life.) Fruck 15999 Lece of Disponetery, crem Marys:	Park 10f. Zip 20 Was Deceder f Yes, specific Yes, specif	one of History Cubar Mil Occupa & done di de retired) Con Inse of her place Cem di Address	specify: tion 18. Mother Carrie and Number Park, 11 s of Facility	n? (Specify Yes Puerto Rican, e of working s Name (First, A	or No- let Ph Aiddle, Maid Nea Numby 12 d 206 Br	Citizen of VUSA 14. Rac Black Specify i. Kind of Bit il Tr den Suman le A or Town, 53 Location- yanto Mary	what Counce - Americck, White, w: Blacusiness/ince avis State, Zip City or Town, land	an Indian, etc. ack dustry Trucking Code) wn, State
3760,	Physician /Medical Examiner but site particular transit street particu	ical Examiner	23a. Part1. Enter the disease, or conshock, or heart failure. List or Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or as b. Due to (or as c. Due to (or as d.	a consequen	nce of):	and the same of			vendulac or respira		bern	and the same of th	Approximate Interval Between Onset and Death
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Division of V	ding Phys h. After this funeral dir	ation: To B	examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigat		ry 28	VOutpation Bb. Time of Injury		Other Sc. Injury	4 Nursi	ing Home 5 28d. Desc	Residence	6 □Othe)
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	To the Hospital or Al within 24 hours after of To the Funeral Direc completely filled in by	Medical	29a. Certifier (Check only only) 29b. Signature and title of certifier	Physician: To the best aminar: On the basis o and manner st	t examınatior	n and/or inv	estigation,	t the time in my opi	nion, death	place, and due to occurred at the	time, date a	and maind place, and place, and place, and place, and place, and place signed	and due to	the cause(s)
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State of Maryland / Department of Health and Mental Hygiene

			For State Registrar		State of M	laryland / Dep	artment of H rtificate of L	ealth ai	nd Mental F	lygiene	2004	36604
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	/Medic Examin			f not institution, give s			4b. City, Town, or	Location of		4c. (County of Death	
			Keninsula	Regional	Medica	1 Center	Salist	bury		U) Conice)
	Funeral Director		5. Social Security N 212-40-77	750 ^{1□}	7. A	ge (In yrs. last birthday) 86 Yrs.	If Under 1 Year Months Days	If Under 2	Min, (Month,	Birth Day, Year) 6,1918	9. Birth Cou MD	place (State or Foreign ntry)
	and .		Usual Residence of 10a. State	Decedent 10b. County		10c. City, Town or L	ocation					10d. Inside City Limits
	f sho	ō	MD	Worces	ter	Berl						1 □ Yes 2 XNo
	28a-	rect	10e. Street and Nur	mber			10f, Zip Code			10g. Citiz	zen of What Cou	ntry?
	3a or	Funeral Director	11226 A	\ssateague	Rd.		21811			US		,
	death ms 2	Jerë	11. Marital Status		12. Was Decedent	Ever in U.S. 13.	Was Decedent of Hi	spanic Origi	n? (Specify Yes or	No- 1	14. Race - Amen	
215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show important: If item 27 is marked other than "natural", or items 23a or 28a-f show appring yor other traumatic avant, I'm Marical Examination and the multiple at anone.	þ	1 Never Marri	ied 2 Married 4 Divorced	Armed Forces 1 ☐ Yes 2X☐ If Yes, Give Year or Dates:		If Yes, specify Cubar 1 ☐ Yes 2X No	n, мехісап, Specify:	Puerto Hican, etc.)		Black, White, Specify: Whit	
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Baltimore,	permit. Pages 1 and 2 sh Department of Health and Importent: If item 27 is m any injury or other traum QDCB.			Service License	20		2. Name and Addres					
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90,	oe execian a	ŭ	resulting in death) t	ast	Due to (or as	a consequence of);						
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-	ding page as		IF FEMALE:	2	3c. If yes, outcome	of pregnancy						
Вох	The law requires that the death certificate has been signed by the attending plage 2 should be detached for use as I	Physician/M	23b. Was decedent in the past 12	months?	1 ☐ Live birth	2 Fetal death 3	Ectopic pregnancy Other (specify)			2	3d. Date of deliver Month	ory Day Year
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	To th withir To th comp	Me	29b. Signature and	title of certifier			29c. License	number		29d. Date	signed (Month,	Day, Year)
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, 1	-		30. Name and addr	ess of person who co	mpleted cause of	death (Item 23a) (Type,	Print)		,	- /		
11	. 3			ENG DO.	100 €	CARROLL S	treet s	Alisk	very m	9		
• 3	Sta Registr		31. Date filed (Mon	NOV 04 20	32. Jegist	death (Item 23a) (Type, CAIDNOL(Serar's Signature	carle					

Gunde Hudson 213-40-7750

State of Maryland / Department of Health and Mental Hygieney 36605 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** Yeer MARY ANN HEARTHWAY 2004 1101 2:47 P /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner 4b. City. Town, or Location of Death 442 MONTICELLO AVENUE SALISBURY WICOMICO If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours 1□M 2€F Yrs 56 Director 219-46-4475 01-14-1948 SNOW HILL, MD. Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits or iteme 23s or 28s-f show other traumatic event, the Medical Examinar must be notified at 1√2 Yes 2 □ No Director WICOMICO SALISBURY 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with 1 Department of Health and Mental Hygiene. Importent: If Item 27 is marked other then "natural" or Item. 11 say injury or other traumair. 28104 ASHBURTON COURT 21801 IISA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☒ No 3 ☐ Widowed 4 🎇 Divorced Specify: WHITE 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) NURSE NURSING 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be LESTER VINCENT HEARTHWAY MILDRED SHOCKLEY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JONATHAN JOHNSON - SON 3727 VILLAGE TRAIL, SNOW HILL, MARYLAND 21863 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) CREMATORY OF DELMARVA 11-03-2004 DELMAR, DELAWARE 21. Signature of Euneral Service Licensee 22. Name and Address of Facility BOUNDS FUNERAL HOME, IN. rest 705 EAST MAIN STREET, SALISBURY, MARYLAND 21804 Part1. Enter the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure: List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) 4 sans /Medical Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed and Due to (or as a consequence of) the attending physician hed for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 DEctopic pregnancy in the past 12 menths? 4□Pregnant at time of death signed by the aid be detached for 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 212 No 3 Probably 4 Unknown 1 Tes peen 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed has certificate 1 ☐ Yes 2 ☑ No or Attending Physician: ector, To Be 25. Was case referred to medical examiner? 26. Place of Death Check only one BROTHERS Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3□ DOA this 28a. Date of Injury (Month, Day Yeer) 28c. Injury at Work? 27. Manper of Death 28b. Time of 28d. Describe how injury occurred Certification: After 5 Pending investigation 1 Natural death. 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours at To the Funerel D completely filled is Hospitel 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medicai and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year) NOV 0 3 2004

Baltimore, Maryland 21215-0036

P.O. Box 68760

Division of Vital Records,

ROLL ST SALISBYRY, M.D.

State of Maryland / Department of Health and Mental Hygien 2001 For State

			1 - State of Maryland / Department of Head State Certificate of Department of Head State Certificate of Department of Head State State of Maryland / Department of Head State Certificate of Department of Head State The State of Maryland / Dep	ealth and Meni eath	tal Hygien Reg. No	
	Physici	an	1. Decedent's Name (First, Middle, Last)		ate of Death Month Da	3. Time of Death
	/Medic	al	David Wesley Hamm 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Lo			2, 2004 7:00 P M
	Examin	er	1601 Busic Church Road Marydel	ocation of Death	40	Queen Anne's
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Months Days I	If Under 24 Hrs. 8. D Hours Min. (A	ate of Birth Month, Day, Year)	9 Birthplace (State or Foreign
	Director		224-72-3535	Oct	27, 19	949 New Hampshire
	land ow		10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
	a-f sh	ctor	MD Queen Anne's Marydel			1 ☐ Yes 2 No
	th with the 23e or 28	ai Director	10e. Street and Number 1601 Busic Church Road 21649		10g. Cit USA	tizen of What Country?
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importants if item 27 is marked other than "natural, or itams 23s or 28s-f show any injury or other treumatic event, the Medical Evantical must be traffied at once.	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Amed Forces? 1 Yes 2 Mo If Yes, Specify Cuban, I Yes, Specify Cuban, I Yes, Specify Cuban, I Yes, Specify Cuban, I Yes, Sive Year or Dates:	oanic Origin? (Specify \ Mexican, Puerto Rican Specify:	Yes or No- n, etc.)	14. Race - American Indian, Black, White, etc. Specify: White
5	natu	etec	15. Decedent's Education (Specify only highest grade completed) (Specify only highest grade completed) (Give kind of work done duri life. DO NOT use retired)	on ring most of working	16b. K	ind of Business/Industry
12	within ene. then he we	Completed	Elementary/Secondary (0-12) College (1-4or 5+) Concrete Division		esident	Construction
<u>5</u>	I Hygi othar	Be Co	17. Father's Name (First, Middle, Last)	8. Mother's Name (Firs		
<u>lar</u>	Menta	To B	Harold Hamm	Elizabeth	Sulliva	n
lan,	2 sho		19a. Informant's Name/Relationship (<i>Type, Print</i>) 19b. Mailing Address (<i>Street and</i>		_	
	1 and Health em 27		Chery1 Hamm/Wife 1601 Busic Church 20a. Method of Disposition (Name of	ch Road, M.		MD 21649 ocation - City or Town, State
JOT.	ages ant of at: If it y or o		20a. Method of Disposition 1 □ Burial 2 ★ Cremation 3 □ Removal from State ' 4 □ Donation 5 □ Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) Chesapeake Cremation			
Baltimore,	mit. F partme sortan / injur	- 1	21. Signature of Funeral Service Licensee 22. Name and Address of Fellows, Ho			
<u>~</u>	Depa Impo any ii		130 Speer	Road, Ches	tertown,	MD 21620
	Physician /Medical Examiner	Examiner	23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, s shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):			Approximate Interval Between Onset and Death 3 months
	eath certificate be executed attending physician and for use as the burial-transit	ledicai	IF FEMALE: 23c. If yes, outcome of pregnancy			
.O. Box	The law requires that the death cer ite has been signed by the attendin bage 2 should be detached for use	Completed by Physiclan/N	23b. Was decedent pregnant in the past 12 months? 1			23d. Date of delivery Month Day Year
rds, P	w requires that been signed b should be deta	ed by PI	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in HEAD and NGCK CANCER	in Part I. 2	. 2	ise contribute to the cause of death?
Vital Records,	ne law re has be ge 2 sho	mplet	CHRONIC OBSTRUCTIVE PULMONARY DUEK CORUNARY ARTERY DISERSE	ASE 2	4a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
<u>ra</u>	nn: Ti	a l		6. Place of Death (Che	performed? Yes 2 No	1 ☐ Yes 2 No
<u>=</u>	J Physician: The la pr this certificate has pral director, page 2	To B	examiner?	4 Nursing Home		6 □Other (Specify)
0	ng Ph fter th	:uo	27. Manner of Death 12 Natural 5 Pending 28a. Date of Injury (Month, Day Year) 28b. Time of Injury at Work?		escribe how injur	
<u>S</u>	tendi leath. tor: A the fu	cati	2 Accident investigation M 1 Yes	s 2 No		
Division of	tet or Attending P rs after death. el Director: After I ed in by the funera	Certification:	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28t. Lo	ocation (Street and ity or Town, State	d Number or Rural Route Number,)
	To the Hospitel or Attending Physician: white 24 hours after death as the feature of the Funerel Director. After this certifics completely filled in by the funeral director.	Medical	29a. Certifier (Check only one) Certifying Physicien: To the best of my knowledge, death occurred at the time, 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion and manner stated.	date and place, and du ion, death occurred at t	ue to the cause(s) the time, date and	and manner as stated. place, and due to the cause(s)
	To t withi To tl	Ž	29b. Signature and title of certifier 29c. License nu		29d. Dat	e signed (Month, Dey, Year)
				41587	11	1 2004
4	Vic		30. Name and address of person who commeted cause of death (Item 23a) (Type, Print)	1,2162	20	
	Sta	te	31. Date filed (Month, Day, Year) 32. Registra's Signature			
		ar	MOV = 3 2004 \ Ke . H And A			

		ľ	1 - For State Registrar	State of Ma	-	artment of H		and Mental H	ygiene	0.01		
			Decedent's Name (First, Middle, Las.	")				2. Date of D	Death	U U 4	3 76 € 60	1 th 7
	Physici: /Medic		ROBERT HENRY HA	APIP				Octobe	r 30,	2004 Year	7:28	РМ
	Examin		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, or	r Location of	of Death	4c. C	ounty of Dea	th	
		*	Washington Adven	ist Hospit	tal	Takoma I			Mon	tgomer	T y	
	Funeral		5. Social Security Number 6. Se	X 7. Age	(In yrs. last birthday) 51 Yrs.	If Under 1 Year Months Days	If Under Hours	Min. (Month, L	Dav. Year)	C	thplace (State or i	Foreign
	Director		Usual Residence of Decedent	Z	51 Yrs.			Dec. 3	30,1952	Nor	th Dakot	.a
	land		10a. State 10b. County		10c. City, Town or Lo	cation					10d. Inside City	Limits
	be filed within 72 hours after death with the Maryland ital Hygiene. d other than "natural", or items 23a or 28a-f show event, the Madical Examiner must be mailfied at	ō	Md. Montgome	ery	Rockville	!					1 XYes 2	2 🗍 No
	the	rec	10e. Street and Number			10f. Zip Code			10g. Citize	n of What Co	ountry?	
	3a or	Funeral Director	16 Hardwicke Place	2		208	350			d Stat	•	
	death ms 2	Jera	11. Marital Status	12. Was Decedent Ev	ver in U.S. 13.	Was Decedent of H	ispanic Ori	gin? (Specify Yes or No., Puerto Rican, etc.)		Race - Ame	erican Indian,	
9	after or Ite	Ē	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☑ No)			i, Puerto Hican, etc.)		Black, Whit		
93	ral',	d by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give TYear or Dates:		1 ☐ Yes 2X No	Specify:		S	pecify: Wh	ite	
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N T	lled v tygie thert		17. Father's Name (First, Middle, Last)	4	Vice-	President	I ICI	rketing or's Name <i>(First, Midd</i>	Fina			
and	ntal hed of	Be	Fred F. Hapip					a Webb	ө, машөп эс	imame)		
Maryland 21215-0036	hould d Me mark matic	ဥ	19a. Informant's Name/Relationship (T	voe Print)	19b Mailir	na Address (Street :		er or Rural Route Num	har City or T	oum State	Zin Coda)	
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importants: If item 27 is marked other than "natural", or Items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.		Cheryl Anne Hapip					Rockville			Lip Code,	
ē,	f Hea f Hea item othe		20a. Method of Disposition		20b. Place of Dispo	sition (Name of		Date		tion - City or	Town, State	-
Ë	Page eent o		1 ☐ Burial 2 XCremation 3 ☐ 1 ☐ Donation 5 ☐ Other (Specify)		Metropol:	natory`or other plac itan Crem	1 11/	ov. 2, 2004	Alexa	ndria	. Va.	
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	Physician	-	Immediate Cause (Final disease or condition		CARDIA	e out	-PU	T			Onset and De	eath
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or o	The law requires that the death certifi sie has been signed by the attending page 2 should be detached for use as	ted	MULTIPLE	ORGAN	/ FAIL	IRE		1	Yes 2□N	√o 3∏Pr	obably 4 Z Unk	known
မင္ပ	has be	pie	HYPOXEN	1iA				24a. Wa	s an 2	24b. Were au	topsy findings ava	ailable
Division of Vital Records,		Completed	SEVERE	PULMON	JARY O	-DEMA		per 1 Tes	formed? 2 X No	death?	2 X No	
/ita	itcian: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	Hospital:				of Death (Check only				
o	Physical this call dir	To	1 ☐ Yes 2 ☑ No 27. Manner of Death	1 A inpatient	2 ER/Outpatien	t 3 DOA	er: 4 🗋 Nu	rsing Home 5 🗆 Res			cify)	
<u></u>	ding F	ion	1 Natural 5 Pending	28a. Date of Injury (Month, Day)	(ear) 28b. Time of Injury	Work		28d. Describe	how injury o	ccurred		
<u>S</u>	or Attending Physician: after death. Director: After this certifica in by the funeral director.	Icat	2 Accident investigation 3 Suicide 6 Could not be	28e Place of Injur	/ - At home, farm, str		Yes 2□l		(Street and N	lumber or Ri	ıral Route Numbe	
<u>≤</u>	for A after Dire	Certification:	4 Homicido determined	building, etc.	(Specify)	set, laddry, office			own, State)	uniber of Fig	irai noule ivuitibei	ν,
	To the Hospital or Attenc within 24 hours after death To the Funeral Director: completely filled in by the		29a. Certifier Certifying Phy	sician: To the best of	my knowledge, death	occurred at the tim	ne, date and	place, and due to the	e cause(s) an	d manner as	stated.	
	n 24 he Fu pletely	edicai	(Check only one) 2 Medical Exam	ner: On the basis of e and manner state	xamination and/or inv	estigation, in my op	pinion, deat	h occurred at the time	, date and pla	ace, and due	to the cause(s)	
	To t To t	×	29b. Signature and title of certifier			29c. License					h, Day, Year)	
	15		Jalle Nell	M.D.	>	D 1	855	1	OCTO	BER,	30,20	04
			39 Name and address of person who constant of the state o	ompleted cause of dea	th (Item 23a) (Type,	Print)	411	1000	Page	4.4	20012	
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		te	NOV 03 200	32. Registrar		/						

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	Physici /Medio Examir	cal	Decedent's Name (First, Middle, Lass	C.	HACKEY	4b. City, Town, or	Location of Death	2. Date of Death Month OCt.	28,2004 4c. County of Dea	th
	Funeral Director		5. Social Security Number 6. Se		e (In yrs. last birthday) 74 Yrs.			8. Date of Birth (Month, Day, Oct.1,	Prince (Year) 9. Bir Co	thplace (State or Foreign ountry) aryland
	ne Maryland 8e-f show offfied at	Director	10a. State 10b. County MOntgo	omery	10c. City, Town or Lo	lver Spr	ing			10d. Inside City Limits 1 ☐ Yes 2X No
	h with th	al Dir	10e. Street and Number 8922 Piney B	ranch Ro	ad	10f. Zip Code	20903	10	og. Citizen of What Co U . S . Z	
980	4 within 72 hours after death with the Maryland Jiene. I then "natural", or items 23e or 28e-f show The Medical Executive could be notified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 Yes 34 N If Yes, Give Year or Dates:	No !	Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 🏋 No	ispanic Origin? (Sp n, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit Specify:B1a	te, etc.
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Baltimore,	permit. Pages 1 and 2 should by Oppartment of Health and Monta Importent; if item 27 is marked eny injury or other treumatic es Once.	+	20a. Method of Disposition 1 XBurial 2 Cremation 3 4 Donation 5 Other (Specify, 21. Signature of Funeral Service Licenses)	20	Lincol	matory or other place n Park C 2. Name and Addres	Cem 11/5	/04 F owden F	oc. Location - City or Rockville uneral H	
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P.O. Box 68760,	death certific e attending p id for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	d. 23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of del Month	ivery Day Year
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Division	ne Hospitel or Attendi 1.24 hours after death ne Funerel Director: A detely filled in by the fi	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injubul	ury - At home, farm, str c. (Specify)	eet, factory, office	1	28f. Location (Stre City or Town,	eet and Number or Ru State)	ral Route Number,
	To the Hospitel or At within 24 hours after o To the Funerel Direct completely filled in by	edical (29a. Certifier (Check only one) Certifying Phy 2 Medical Exami	rsician: To the best of iner: On the basis of and manner sta	of my knowledge, death examination and/or in- ited.	n occurred at the tim vestigation, in my op	e, date and place, a finion, death occurr	and due to the cau ed at the time, dat	ise(s) and manner as e and place, and due	stated. to the cause(s)
)	To the health within 24 To the F	Me	29b. Signature and title of certifier	Down	Un	29c. License		290	Date signed (Month	
			30. Name and address of person who or Alan R. Segal				or., Sil	ver Spr	ing, MD	20902
	Sta Registr	-	31. Date filed (Month, Day, Year) NOV 0 3 2004	32 Registra	ar's Signature	Sparks		T		

State of Maryland / Department of Health and Mental Hygien 0 0 1 36609 1 - For State Registrar Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Helen Dorothy Hanson October 30, 2004 21:57 P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Chester River Hospital Center Chestertown Kent 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) **Funeral** Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 1 □ M 2 💢 F Director 053-20-4763 76 Yrs. 27, 1927 New York Usual Residence of Decedent death with the Maryland 10a, State 10b, County 10c. City, Town or Location Show 10d. Inside City Limits items 23e or 28e-f shov Md Oueen Anne's Chestertown Director 1 Yes 2 No 10e. Street and Number 10f Zin Code 10g. Citizen of What Country? 232 Merganser Drive 21620 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Xyes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, other treumetic event, the Medical Examiner. Pages 1 and 2 should be filed within 72 hours after Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ŏ 1 ☐ Yes 2 X No Specify: White Specify: 3 Widowed 4 Divorced neturel 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 5+ Healthcare Nurse 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be is marked of Henry Hanson Ruth Anderson ျှ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2. Department of Health a Importent: if item 27 is eny injury or other treu once. Eleanor Repp/Personal Rep. 232 Merganser Drive, Chestertown, MD 21620 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Chesapeake Cremation | Nov.2, 2004 Stevensville, MD ` 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee ^{22. Name and Address of Facility} Fellows, Helfenbein & Newnam, P.A. 130 Speer Road, Chestertown, MD 21620 fellows 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a cons - uence of) Examiner Sequentially list conditions, Examiner cause. Enter Underlying Cause (Disease or injury that initiated events Due to for as a consequence of The law requires that the death certificate be executed use as the burial-transit and resulting in death) Last Due to (or as a consequence of): Box 68760. attending physician Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4□Pregnant at time of death 5 Other (specify) P.O. | the a 9 Unknown 9 Unknown à Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ Be Completed 2 □ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an certificate has autopsy performed? 1 ☐ Yes 2 No Hospitel or Attending Physicien: 25. Was case referred to medical 26. Place of Death (Check only one) examiner Other: Certification: To 1 🗌 Yes 2 No 2 ER/Outpatient 3 DOA 1 Inpatient 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1-Natural 5 Pending death. investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 Could not be determined 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) after 4 | Homicide 24 hours a 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

and manner stated. (Check only one) 2[within 2 the 29b. Sign 2 ure and title of Aert 29d. Date signed (Month, Day, Year) 00060301 woo completed cause of death (Item 23a) (Type, Print Name and address of lod Shen RD STUS CHUSTER TOWN, MD VET MEK, w

State Registrar

strar's Signature

State of Maryland / Department of Health and Mental Hygiene 1 - For Stete Registrar 36610 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Oct. 23, 2004 **Physician** 02:00 Warren Dale Haney /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Chester River Manor Chestertown Kent | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Apr. 12, 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Funeral 1 XM 2 □ F 77 Director 199-21-6171 PĂ Usual Residence of Decedent with the Maryland 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-1 show the Medical Examiner nust be notified at 1 X Yes 2 No Director MD Kent Chestertown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ŏ 21620 USA 225 Princess Anne Dr. Itams 23a death Funera 12. Was Decedent Ever in U.S. Amed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. Int: If item 27 Is marked other than "natural", or Ital 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No White ģ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Goelist 0i111 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Edith Custead Charles Haney 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Violet Hanev 225 Princess Anne Dr., CHestertown, MD 21620 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State cemetery, crematory or other place) □ XBurial 2 ☐ Cremation 3 ☐ Removal from State Department of Important: If any injury or once. Paul's Cemetery Oct.26,2004Chestertown, MD 1 4 ☐ Donation 5 ☐ Other (Specify) Name and Address of Facility llows, Helfenbein & Newnam, O Speers Road, Chestertown, 21. Signature of Funeral Service Licenses Fe 1 1 1 3 0 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardian or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine The law requires that the death certificate be executed burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year Month Day 4 Pregnant at time of death 5 Other (specify) P.0. 1 ☐ Yes 2 ☐ No the 9 Unknown 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. à Poor oral entable 1 Yes Z No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has le 2 autopsy performed? page certificate 1 Yes 1 ☐ Yes 2 ☐ No 2 No the Hospital or Attanding Physician: 25. Was case referred to medical Be 26. Place of Death Check onl one examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Natural After 5 Pending 1 ☐ Yes 2 ☐ No investigation hours after death. ☐ Accident Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) þ 4 Homicide thin 24 hours a tha Funaral D 11 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Examine: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie Medical (Check only one) 29b. Signature 2 0 0060301 Who completed cause of death (Item 23a) (Type, Prot)

A Mon, Mb I H Stevel PA Survis Cotossa 30. Name and address of per 31. Date filed (Month, Day, Year) 32. Registrar's Signature State OCT 2 5 2004 Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 004 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Beverly Batchelder Harrison October 0 30, 2004 9:20AM M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Prince George's Morningside House of Laurel Laurel | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Sept. 10,1924 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign 1□M 2₩F 80 Yrs. 577-38-2993 Director Washington DC Usual Residence of Decedent with the Maryland 10a State 10b County 10c. City. Town or Location 10d. Inside City Limits 28a-f show other treumatic event, the Medical Examinating be notified at Suitland 1 Yes 2 No Director Maryland Prince George's 10g. Citizen of What Country? U.S.A. 10e. Street and Number 10f. Zip Code 20746 2904 Sunset Lane or items 23a death Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give A Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Race - American Indian, Black, White, etc. 2 should be filed within 72 hours after of and Mental Hygiene.

Is marked other then "neturet", or iter 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No þ Specify: 3 ☐ Widowed 4 ☐ Divorced White Completed Decedent's Usual Occupation
 (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) P.G. County Public Elementary/Secondary (0-12) College (1-4or 5+) Secretary Schools 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Merton Ĵ. Batchelder Katherine Jolliffe 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) s 1 and 2 s if Health an Junius H. Harrison (Husband) 2904 Sunset Lane Suitland, Maryland 20746 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If ite eny injury or ott Nov. 4, 1 ABurial 2 Cremation 3 Removal from State Washington National Cem. 2004 * 4 ☐ Donation 5 ☐ Other (Specify) Suitland, Maryland 22. Name and Address of Facility Lee Funeral Home, Inc. 21. Signature of Funeral Service Licensee DUCe. 6633 Old Alexandria Ferry Road Clinton, CORDA m001284 MD20735 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Priysician Failure to thrive months /Medical Due to (or as a consequence of): Examiner Serile dementia Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence or). Examine burial-transit The law requires that the death certificate be executed aftending physician and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medicai the as 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☒ No 23d. Date of delivery Live birth 3 Ectopic pregnancy Month Year Day signed by the af 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a Was an 1 Yes 2 100 To the Hospitel or Attending Physicien: 25. Was case referred to medical examiner? 26. Place of Death Check onl one Other: 4 Nursing Home 5 Residence 6 Other (Specify) @55131ed live Hospital: 1 ☐ Yes 2 📉 No P 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 DOA After this funeral of 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred Certification: 1 Natural 5 Pending death. investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 Could not be determined 3 TSuicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 4 Homicide after within 24 hours a

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completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai (Check only one) and title of certifier 29b. Signature 29d. Date signed (Month, Day, Year) 022780 m 30. Name and address of son who completed cause of death (Item 23a) (Type, Print) Schissler M.D. 7500 Greenway Center Drive # 430 Greenbelt, MD 20770 Peter 31. Date filed (Month, Day, Year) State Registrar

			For State Registrar	State of Ma	ryland / Depai <i>Cert</i>	rtment of He Fificate of D	alth and Mo eath	ental Hygie Reg	2001	36612
	Physici /Medic		1. Decedent's Name (First, Middle, La Emma	C .	Не	ealy		2. Date of Death October	29, 2004	3. Time of Death 12:50PM M
	Examin		4a. Facility Name (If not institution, giv Southern Maryla			4b. City, Town, or L $C1i$ 1	ocation of Death nton		4c. County of De Prince	George's
	Funeral Director		377 = 0 = 7.	ex 7. Age	(In yrs. last birthday) Yrs.		If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y March 24	(ear) 1920 W	Birthplace (State or Foreign Country) Jashington, DC
	ryland how		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Loca					10d. Inside City Limits
	the Ma	Director	Maryland Prince Ge	eorge's		Upper	Marlboro		. Citizen of What	1 Yes 2 No
	th with 23a or	ai Dir	4903 Ashford I	rive		20772			J.S.A.	Country
980	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "netural", or items 23e or 28e-f show styr injury or other traumatic event, the Medical Exaction must be notified at ances.	by Funerai	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 ▼N If Yes, Give Year or Dates:	0	as Decedent of Hisp Yes, specify Cuban, Yes 2 No	panic Origin? (Spec Mexican, Puerto F Specify:	cify Yes or No- kican, etc.)	Black, WI	nencan Indian, hite, etc. White
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and	be filed ntal Hygi ed other event, L	Be	17. Father's Name (First, Middle, Last, Joseph T. Bre			1	8. Mother's Name	(First, Middle, Ma	,	
aryla	2 should be filed withir and Mental Hygiene. Is marked other than aumatic evant, ILE M.	၉	19a. Informant's Name/Relationship (Type, Print)	19b. Mailing	Address (Street and				, Zip Code)
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Baltimore,	permit. Pages 1 and Department of Healt Important: If item 2 any injury or other once.		20a. Method of Disposition 1 ↑ Burial 2 □ Cremation 3 □ ↑ 4 □ Donation 5 □ Other (Specification)			11 Cemete	ry	Su		Maryland
Ball	permit Depart Import any in		21. Signature Funeral Service bice		/	Name and Address 533 Old A				inc. iton, MD20735
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	/Medical Examiner		resulting in death)	Due to (or as a	lo Bar, consequence of):	Thomas	101+	1		W-Westerna
	pe is	iner	Sequentially list conditions, Tary laborate immediate cause. Enter Underlying Cause (Disease or injury	b. Due to o as a	consequence of):	7.0.0773	20/5	00.0		CARROLL SIN
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68760,	ate be hysicia the bur	edicai		d.						
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ds, P	The law requires that the ste has been signed by th bage 2 should be detache	d by P	Part II. Other significant conditions of the part of t		t not resulting in the und	lerlying cause given	in Part I.			to the cause of death?
Division of Vital Record	law requas been 2 should	pietec		,				24a. Was an	24b. Were	autopsy findings available
I Re		Com						autopsy performe 1 Yes 2 A	d? prior to death? No 1 □ Ye	completion of cause of
Vita	ysician: The lis certificate hadirector, page	Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:	at 2 ER/Outpatient	3 DOA Other:	6. Place of Death		e 6 □Other (Sp	
n of	Attanding Physician: or death. ector: After this certific by the funeral director.	on: To	27. Manner of Geath 1 Datural 5 Pending	28a. Date of Injury (Month, Day	28b. Time of	28c. Injury at Work?		3d. Describe how		<i>весту)</i>
ISIO	or Attandii after death. Director: A in by the fu	ication	2 Accident investigation 3 Suicide 6 Could not b		ry · At home, farm, stree		s 2 No	of Location (Street	at and Number or F	Rural Route Number,
Div	rs after al Dire ed in b	Certification:	4 Homicide determined	building, etc.	(Specify)	n, ractory, critico		City or Town, S		100.0 (100.0)
	To the Hospital or Attanding Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exar	ysician: To the best of niner: On the basis of and manner stat	f my knowledge, death o examination and/or inve ed.	occurred at the time, stigation, in my opin	date and place, ar ion, death occurred	nd due to the caus d at the time, date	e(s) and manner a and place, and du	as stated. ue to the cause(s)
•	To the within 2 To tha Complet	2	29b. Signature and title of certifier	ama		29c. License n	umber		Pate signed (Mor	oth, Day, Year)
(RA		30. Name and address of person who	completed cause of de	ath (Item 23a) (Type, Pr	SPIN	Yazdani	, M.D.		, , ,
JAN.	Sta	te	31. Date filed (Month, Day, Year)	2004 32. Baistra	r's Signature	made!	0 200	100		
	Registr	ar	- MOA 0.9	ZUUT A TANK	77					

	i	1 - For State Registrar	State of Ma	aryland / Depa <i>Cel</i>	artment of He rtificate of D	ealth and Me Death		ene2004	36613
Physici /Medic		Decedent's Name (First, Middle, Last) JAMESANNA TURNER H					Date of Death Month	29, 2004	3. Time of Death 10:17 P M
Examin		4a. Facility Name (If not institution, give s 5820 FUCHS CIRCLE			4b. City, Town, or L			4c. County of Death	
Funeral Director			M 2□ X F 7. Age	e (In yrs. last birthday) 86 Yrs.	If Under 1 Year Months Days	Hours Min. 8	Date of Birth	1918 GEO	place (State or Foreign RCTA
death with the Maryland ms 23s or 28s-1 show rmust be notified at	Director	Usuel Residence of Decedent 10a. State 10b. County MARYLAND CHARLES		10c. City, Town or Lo	RY				10d. Inside City Limits 1 ☐ Yes 2 No
th with th	al Dire	5820 FUCHS CIRCLE	PLACE		10f. Zip Code 2065	8		g. Citizen of What Cou NITED STATI	
ē ##	by Funeral	11. Marital Status 1 Never Married 2 Married 3 M Widowed 4 Divorced	2. Was Decedent I Armed Forces? 1 ☐ Yes 2 M I If Yes, Give Year or Dates:	10	Was Decedent of Hist f Yes, specify Cuban, 1 ☐ Yes 2 ሺ No	panic Origin? (Specif Mexican, Puerto Ric Specify:	fy Yes or No- can, etc.)	14. Race - Ameri Black, White, Specify: BL	, etc.
Maryland 21215-0036 d 2 should be filad within 72 hours after th and Mental Hygiene. ?? Is marked other than "natural", or Ite traumatic event, the Medical Exam is	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)		(Give	dent's Usual Occupati kind of work done du DO NOT use retired) JRSE	ion ring most of working	10	6b. Kind of Business/Ir MEDICAL	,
Iryland 2 should be filad ad Mental Hygi markad other matic event, t	To Be C	17. Father's Name (First, Middle, Last) JAMES TURNER				8. Mother's Name (F		aiden Sumame)	
re, Maryla s 1 and 2 should I Health and Men ttem 27 Is marka other traumatic		19a. Informant's Name/Relationship (Type MELVINA MIDDLETON						City or Town, State, Zip HINGTON, D.	
Baltimore, permit. Pages 1 an Department of Heal Important: If item 2 any injury or other		20a. Method of Disposition 1		20b. Place of Dispo cemetery, crer SMITH CHAPE	sition (Name of natory or other place) L CHURCH CEM	Date NOVEMBER	R 4,2004	Oc. Location - City or To	own, State
Ball permit Depart Import any in		LYDIA C. THORNTO	N JOHNSON	M00583 3	HORNTON FI 439 LIVING	UNERAL HON GSTON ROAI	Æ P.A.	N HEAD, MAR	RYLAND 2064
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P.O. BOX 6: nat the death certific d by the attending p stached for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	tc. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of delive Month	ery Day Year
wraquires that been signed by should be deta	by	Part II. Other significant conditions conf	ributing to death bu	ut not resulting in the u	nderlying cause given	in Part I.		cco use contribute to the	
	Be Completed	25. Was case referred to medical examiner?			2	26. Place of Death C		prior to co death? 1 \(\text{Yes}	opsy findings available impletion of cause of 2 No
UNISION OT VITA Hospital or Attanding Physician: 24 hours after death. Funeral Director: After this certific tely filled in by the funeral director.	Certification: To I	1 Yes 2 No Ho	28a. Date ol Injur (Month, Day	Year) Injury	28c. Injury a Work? M 1 Ye	t 280 s 2 □ No	I. Describe how	ce 6 Other (Specify injury occurred	
UIV urs after ral Direct		4 Homicide determined	building, etc				City or Town,		
0 0 0	Medical	29a. Certifier 1 Certifying Physical Check only one)	er: On the best of and manner sta	ol my knowledge, death examination and/or inv ted.	occurred at the time, restigation, in my opin	date and place, and ion, death occurred	due to the cau at the time, date	se(s) and manner as si e and place, and due to	(ated. the cause(s)
To the within To the compl	≥	29b. Signature and title of certifier 9 um'r m-				50883		Date signed (Month,	
206		30. Name ind address of person who con 11655 WINESUP	npleted cause of de	eath (Item 23a) (Type,	20646	yuhia	M. TAgo	or! MD, FC	AP
Sta Registr		31. Date filed (Month, Day, Year) NOV 0 3 20	04 32. Hagistra	eath (tem 23a) (Type,	best				

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			1 - For State Registrar	State of Maryla		artment of H rtificate of I			ene 0 0 1	36614
	Physici /Media		1. Decedent's Name (First, Middle, Last,)	Isaa	PCS		2. Date of Death Month	Day Y	3. Time of Death
	Examir		4a. Facility Name (If not institution, give	street and number)	l abo	4b. City, Town, or	Location of Death	ami	4c. County of	Death
	. Funeral		5. Social Security Number 6. Sec		last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Wico	. Birthplace (State or Foreign
	Director		296-18-9399 Usual Residence of Decedent	¶M 2□F 8	5 Yrs.	World Days	Tiodis (VIII).	08-08		OHIO
	show	5	10a. State 10b. County		ity, Town or Lo					10d. Inside City Limits
	r 28a-f	recto	MD WICOMIO	CO F	RUITLAN	10f. Zip Code		100	g. Citizen of Wha	1 Yes 2 No
	ath with	raiD	113 AUTUMN LANE				21826		USA	•
980	be filed within 72 hours after death with the Maryland that Hygiene. Ed other then "naturel, or Items 23e or 28a-f show event, the Medical Examiner must be notified at	t by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U Armed Forces? 1 XYes 2 ☐ No If Yes, Give Year or Dates:		Was Decedent of Hi f Yes, specify Cuba I ☐ Yes 2 ☑ No	ispanic Origin? (Spin, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)		American Indian, White, etc. WHITE
Maryland 21215-0036	s within 72 hours piene. r then "naturel", or	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	cation e completed) College (1-4or 5+) 5+	(Give	lent's Usual Occupa kind of work done o DO NOT use retired OR	furing most of work	ing 16	MEDIC	
pu	be filed ital Hygid of other event, the	Be C	17. Father's Name (First, Middle, Last)				18. Mother's Name	(First, Middle, Ma		
ıryla	should by nd Menta marked matic ev	10	WILLIAM ISAACS 19a. Informant's Name/Relationship (Ty)	oe. Print)	19h Mailin	g Address (Street a	CARRIE S		City or Town Sta	to Tin Code)
	and 2 sealth ar n 27 is		JAMES W. ISAACS -	SON	517 I	RUID HIL				
Baltimore,	Pages 1 ent of Hi ent if iter ry or oth		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	cemetery, cren	sition (Name of natory or other place OF DELM	9)		C. Location - City	
Balti	permit. Pages 1 and 2 should b Department of Health and Ments Importent: If item 27 is marked any injury or other traumatic e once.		21. Signature of Funeral Service License		22	. Name and Addres	s of Facility BOU	NDS FUNE	RAL HOME	
	2/		23a. Part1. Enter the disease, or complishock, or heart failure. List only or	eations that caused the dea					-	Approximate Interval Between
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	AHZKein	ur's	Disease				Onset and Death
	Examiner		Sequentially list conditions,	Due to (or as a consec	quence or):					/
Ī	ecuted and transit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Jue to (or as a consec						
8760,	cate be executed physician and the burial-transit	dical Ex	c	Due to (or as a consec	quence of):					
Box 6	death certifi e attending od for use as	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregn 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of c 9 □ Unknown	al death 3	Ectopic pregnancy Other (specify)			23d. Date of Month	delivery Day Year
s, P	Se GO	by	Part II. Other significant conditions con	tributing to death but not res	sulting in the un	derlying cause give	n in Part I.	23e. Did tobac	\sim	e to the cause of death? Probably 4 _Unknown
Œ	0 5 0	Completed						24a. Was an autopsy performa	r) prior deat	
	Physicien: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?				26. Place of Death	(Check only one)	No 1 1	(es 20 No.
of	ding Phys n. After this funeral di	tion: To	1 Yes 22 No 27 Manner of Death Natural 5 Pending investigation	ospital: 1 Appatient 2 28a. ate of Injury (Month, Day Year)	ER/Outpatient 28b. Time of Injury	28c. Injury Work	at 2	ne 5 Residenc		Specify)
Division	Hospitel or Attendi 24 hours after death. Funerel Director: A tely filled in by the fu	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h building, etc. (Specif	ome, farm, stre fy)	1117		8f. Location (Stree City or Town, S	t and Number or state)	Rural Route Number,
	To the Hospitel or within 24 hours afte To the Funerel Dir. completely filled in 1	edical	29a. Certifier (Check only one) 1 Certifying Physical Exemination (Check only one)	icien: To the best of my knower: On the basis of examination and manner stated.	owledge, death ation and/or inv	occurred at the time estigation, in my opi	e, date and place, a inion, death occurre	nd due to the caus d at the time, date	e(s) and manner and place, and o	as stated. due to the cause(s)
)	To the within 2 To the complet	W	29b Signature and title of certifier	(10)	w	29c. License	number $\lambda 627$	E 29d.	Date signed (Me	>/
NA.	1		30. Name and address of person who con	npleted cause of death (Item	n 23a) (Type, F	7 7 7 7	Solid		0 2	1802
	Sta Registr	_	31. Date filed (Month, Day, Year) NOV 0 3 20	32. Registrar's Signa	ature 4	Spork	2	O' wi		

			1- For State of State of Ragistrar	Maryland / Depa <i>Ce</i> a	artment of Health rtificate of Deat	h and Mer <i>th</i>	ntal Hygie Rag.	2004	36615
	Physic	an	1. Decedent's Name (First, Middle, Last)				Date of Death Month		3. Time of Death
	/Medi		Kenneth Jordo			0	1	Day Year	1039 AM
	Exami	ner	4a. Facility Name (If not institution, give street and numb Howard County Hospital	er)	4b. City, Town, or Location Columbia	on of Death		4c. County of Death	
	Funeral			Age (In yrs. last birthday)		der 24 Hrs. 8	Date of Birth	Howard	-1 (0)
l.	Director		579-62-4908 1XM 2□F	56 Yrs.	Months Days Hour	rs Min.	(Month, Day, Year)	gar) Cou	place (State or Foreign intry) ington, DC
	and w		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Lo	cation			T.	10d. Inside City Limits
	death with the Maryland ms 23a or 28a-f show	to	D.C. N/A	Washingto					1 ∑Yes 2 ☐ No
	h the	Director	10e. Street and Number		10f. Zip Code		10g.	Citizen of What Cou	ntry?
	23a c	alD	424 Irving Street, N.W.		20010		υ	Jnited Sta	tes
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "netural", or Items 23a or 28a-1 show any hytury or other treumetic event, the Medical Event are must be notified at once.	by Funeral	11. Marital Status 12. Was Decede Armed Force	s? 1965- I	Was Decedent of Hispanic of Yes, specify Cuban, Mexic	Origin? (Specify ican, Puerto Rica		14. Race - Americ Black, White,	can Indian,
21215-0036	urs aff	by F	1 X Never Married 2 Married 1 X Yes 2 If Yes, Give 3 Widowed 4 Divorced Year or Date	1967	1 ☐ Yes 2 🏹 No Speci	eify:		Specify:	A
S O	72 ho	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Deced	lent's Usual Occupation	anat of wording	166	African A	
12	vithin ne. han	mple	Elementary/Secondary (0-12) College (1-4)	or 5+)	kind of work done during m DO NOT use retired)			nited Tecl	
	filed v Hygie ther t		17. Father's Name (First, Middle, Last)	Admir	istrative As			orporation	<u> </u>
Maryland	ld be ental ked o ic eve	To Be	Absalom Frederick Jordan	. Sr.		other's Name <i>(Fii</i>		Campbell	
ary	shou and M s mar umet	-	19a. Informant's Name/Relationship (Type, Print)		g Address (Street and Nurr				Code)
	and 2 salth a n 27 is		William A. Jordan (broth		Edinburgh D				22553
ore	of He		20a. Method of Disposition 1XX6urial 2 ☐ Cremation 3 ☐ Removal from Sta	20b. Place of Dispo	sition (Name of natory or other place)	Date		Location - City or To	
Baltimore,	Timent Tent:		`4 ☐ Donation 5 ☐ Other (Specify)	Lincoln	Memorial	11/8/0	4 S	uitland, M	4D
Ba	permil Depar Impor any Ir		21. Signature of Funeral Service Licensee	22	Name and Address of Fac	cility McGui	re Fune	ral Servic	:e
			23a. Part 1. Enter the disease, or complications that cause	ed the death. Do not ente	7400 Georgia	Ave. N	.W., Wa	shington,	D.C. 20012 Approximate
	Physician		Immediate Cause (Final	i line.					Interval Between Onset and Death
	/Medical		disease or condition resulting in death) Due to (or.	as a consequence of):	LINFA	ARCTI	ON	1	
П	Examiner		Sequentially list conditions, b. ATH	BROSCLE	POTIC C	cirdie	22000	(00	
	sit s	lner	ause. Enter Underlying Cause (Disease or injury	as a consequence of.			d	الالمادا	
	xecution and all-tran	Examiner	that initiated events	as a consequence of):					
68760,	icate be executed physician and s the burial-transit			20 2 3377334237733 31).					
89	tificate ig phy as the	ledical	0.						
Š	leath cert attending I for use a	an/N	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcom		Ectopic pregnancy			23d. Date of delive	ury
P.O. B	The law requires that the death certificate be executed the has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/M		at time of death 5	Other (specify)			Month	Day Year
<u>ۃ</u>	w requires that the de been signed by the should be detached	y Ph	Part II. Other significant conditions contributing to death	but not resulting in the un	derlying cause given in Par	rt I.	23e. Did tobacc	o use contribute to th	e cause of death?
Records,	quires an sign	ed by					1 🗆 Yes		ably 4 Dunknown
ဝင္ပ	law re las bee	Completed				2	24a. Was an	24b. Were autop	osy findings available
Ť	iù ce	Com					autopsy performed?	death?	npletion of cause of
Vital	ilcien: Th certificate rector, pag	Be	25. Was case referred to medical examiner?		26. Pla	ice of Death (Chi			
ō	Phys this ral dii	- To	1 ☐ Yes 2 ♠ No Hospital: 1 ☐ Inpa 27. Manner of Death 28a. Date of In					6 □Other (Specify	9
חכ	ding Afte fune	atlon:	27. Manner of Death 1. Natural 5 Pending 2 Accident investigation 28a. Date of Ir (Month, L	jury 28b. Time of Injury	28c. Injury at Work? M 1 Yes 2		Describe how in	jury occurred	
DIVISION	r Attandii er death. rector: A by the fu	ifica	3 Suicide 6 Could not be	njury - At home, farm, stre		28f. L	ocation (Street	and Number or Rural	Route Number.
5	rs afte el Dir ed in	Certiflo	4 Tromede Building,	etc. (Specify)		0	City or Town, Sta	ate)	
	To the Hospitel or Attantwithin 24 hours after deatl To the Funerel Director: completely filled in by the	edical	29a. Certifier (Check only one) Certifying Physician: To the besis and manner and manner.	or examination and/or invi	occurred at the time, date a	and place, and d	ue to the cause	(s) and manner as sta	ated.
	o the ithin 2 o the omple	Med	one) and manner : 29b. Signature and title of certifier	stated.	29c. License number			Date signed (Month, D	
			11 - 1	no	02560			Jate signed (Month, L	
	19+1		30. Name and address of person who completed cause of	death (Item 23a) (Type, P					
			LEVAN KUCK, HO	wand a	B HUSP.	COLU	mBiA	mp:	21044
	Sta Registra			trar's Signature	Sporks				
	riegisti		1104 00 2004	P	spours				

			For	State of Ma	aryland					nd M	ental Hyg	giene		
			1 - State Registrar			Ce	rtificate	of L	Death			leg. N.P. ()	14	36616
Н	Pĥysici	an	1. Decedent's Name (First, Middle, L THOMAS	,	TER						2. Date of Dea Month	Day	Year	3. Time of Death
	/Medic		4a. Facility Name (If not institution, gi		161		4b. City. To	wn or	Location of	Death	10	30 20 4c. County	$\overline{}$	17. 304 M
	Examir	er	Holy Cross Hospi						Sprin				tgome	
	Funeral		5. Social Security Number 6.	Sex 7. Ag	e (In yrs. las	t birthday)	If Under 1 Y		If Under 2	_	8. Date of Birtl (Month, Da)	1	9. Birth	place (State or Foreign
	Director		579-36-9171	1 XX M 2□F	75	Yrs.	Months	ays	riours	WIII.	July 20	1929	Wash	ington, DC
	land		Usual Residence of Decedent 10a. State 10b. County		10c. City, 1	Town or Lo	cation							10d. Inside City Limits
	Many -f sh	to	Maryland Montgon	nery	Silv	ver S	pring							XXYes 2 □ No
	h the	irec	10e. Street and Number				10f. Zip Co	ode				10g. Citizen of	What Cou	ntry?
	th wit	al D	2128 Bucknell Te	errace			20	902				United	Stat	es
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 Is marked other then "neturel", or Items 23e or 28e-f show any injury or other treumette event, I'm Medical Evertiver must be traitlised at Once.	by Funer	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	12. Was Decedent Armed Forces? 1 Tyes 2 1 If Yes, Give Year or Dates:		- '	Was Decedent f Yes, specify	Cubar	spanic Orig n, Mexican, Specify:	in? (Spe Puerto i	cify Yes or No- Rican, etc.)	Bla	ce - Americk, White,	
ğ	2 hou	ted	15. Decedent's 8	ducation		I6a. Dece	dent's Usual C	ccupa	tion			16b. Kind of B	usiness/lr	dustry
21215-0036	thin 7 e. en "n	ηpie	(Specify only highest gas Elementary/Secondary (0-12)	ade completed) College (1-4or 5	i+)	(Give life.	kind of work of DO NOT use r	done di retired)	uring most	of workir	ng			•
7	ed wi ygien ner th	Con		5+	1	Profe	ssor o							versity
Maryland	be fill be fill be fill be don't	Be	17. Father's Name (First, Middle, Las								(First, Middle,	Maiden Suman	ne)	
Ĕ	hould d Mei mark metic	ို	William E. Jeten 19a. Informant's Name/Relationship			10b Mailir	a Address (S	troot o			lliott (Route Numbe	City or Town	C4- 4- 7:	. 0. 4-1
<u>s</u>	nd 2 s lth an 27 Is :		Josiah E. Jeter	(brothe							linton,			
ē,	f Hea f Hea item othel		20a. Method of Disposition		20b. Plac	e of Dispo	sition (Name on atory or other	of	Ţ			20c. Location		
Ê	Page Fire of the or of the		1 XBurial 2 ☐ Cremation 3 ['4 ☐ Donation 5 ☐ Other (Spec				oln Cei	,	´ 1	11/6	/04	Brentwo	ood,	MD
Baltimore,	rmit. ppartir poorte y inju		21. Signature of Funeral Service Lice	insee / /	1	22	. Name and A	ddres	s of Facility	McGu	ire Fur	eral Se	ervic	e
<u> </u>	80 = 50		Showask	. Clypu	in						N.W., W			20012
			23a. Part1. Enter the disease, or con shock, or heart failure. List only	nplications that caused one cause on each lin	the death. (Do not ent	er the mode of	f dying	, such as c	ardiac o	r respiratory arr	est,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition resulting in death)	_ a	Poszi	ple	. se	ps	15					Onset and Death
	/Medical Examiner		1930iting in doubly	Due to (or as	a consequen	ce of):	. 11.		1	00	1 0 1	- /		0111
		er	Sequentially list conditions, if any, leading to immediate	b. Due to (or as	a consequen	ice of):	CON	VCL	MC	1	ual.	rance	ue	24 ms
	d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events		L	cha	stall	U	Pro	3500	eli ca	Luce		
Ó	an an rial-tr	Еха	resulting in death) Last	Due to (or as	a consequen	ce of):	1	06			/ .			
68760,	icate be executed physician and s the burial-transit	edicai	•	_ d	rites	hu	91	- 10	The	((ide			
_			IF FEMALE:	20 11										
Вох	ires that the death cer signed by the attendin d be detached for use	Physician/M	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome	2 Fetal de	ath 3□	Ectopic pregn						te of delive	Day Year
P.O.	the de	ysic	1 □ Yes 2 ☒ No 9 □ Unknown	4□Pregnant at 9□Unknown	ame or dead	1 3	Other (specif	y)						,
	s that ned b e deta	by Pr	Part II. Other significent conditions	contributing to death bi	ut not resultin	g in the ur	nderlying caus	e giver	n in Part I.		23e. Did tol	pacco use cont	ribute to th	ne cause of death?
202	w require been sig should b					<u> </u>					1 □ Ye	s 2 No	3 Prob	ably 4 Unknown
၀ ဂ	aw re	Completed									24a. Was a		Vere auto	psy findings available
ž	hysicien: The law ns certificate has b I director, page 2 s	Com								_	autops perform	ned?	death?	inpletion of cause of
Ita	cien: ertific actor,	Be	25. Was case referred to medical examiner?							of Death	(Check only on	7		
0	Physi this c al dire	Lo L	1 ☐ Yes 2 ☑ No	Hospital:		Outpatien		Other	4 🗀 IVUIS		e 5 Reside)
n	ding F h. After funer	llon	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injur (Month, Day	Year) 28	b. Time of Injury		Mork?	at } es 2⊡No		3d. Describe ho	w injury occurr	ed	
Division of Vital Records,	Attending Ph er death. ector: After th by the funeral	Certification:	3 Suicide 6 Could not t	OB Place of Init	rv - At home	. farm. stre					Bf. Location (St.	reet and Numb	er or Rum	l Route Number,
2	after after Dire d in b	erti	4 Homicide	building, etc	c. (Specify)	,,	, idoloty, on	1100			City or Town	, State)	5. 57 Flara	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
	To the Hospitel or Attending Physicien: The law requires that the death certit within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use a		29a. Certifier 1 Certifying P	hysicien: To the best of	of my knowled	dge, death	occurred at th	ne time	, date and	place, a	nd due to the ca	iuse(s) and ma	nner as st	ated.
	the H in 24 the F pplete	Medical	0110)	miner: On the basis of and manner sta	ted.	and/or inv				occurre	d at the time, da	ate and place, a	and due to	the cause(s)
	To To con	2	29b. Signature and title of certifier	LABIADA	9 1	10			number	1.6	2	d. Date signed	(Month, I	Day, Year)
	7			naha			1	16	08	0		10/3	10/0	4
			30. Name and address of person who KShAMA G		eath (Item 23	a) (Type, I	Print)	1	131	, 0	1 614	u Ca.		0 20913
	Sta	te :	31. Date filed (Month, Day, Year)	32. Registra	r's Signature	E I	1	11	w 12.	1	0 3110	r spain	3 101	0 00 110
	Registr		NOV 0 3 2	104 Sens	رمس	Ø	spou	KN	P					

State of Maryland / Department of Health and Mental Hygiene 1 - Stete Registrar 36617 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Jacqueline 1, Andree Jarman 2004 November 8:25 A. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Rockville Shady Grove Adventist Hospital Montgomery If Under 1 Year If Under 24 Hrs. Wonths Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Funeral Birthplace (State or Foreign Country) 1 ☐ M 2 🎛 F Months Director 79 223-56-9250 March 20,1925 Morocco Usual Residence of Decedent the Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if itam 27 is marked other than "natural; or Itams 23a or 28a-f show any injury or other traumatic evant, the Medical Evantinating the notified at once. 10a. State 10h. County 10c. City, Town or Location 10d. Inside City Limits Directo 1 X Yes 2 ☐ No Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? # 807 10 East Lee Street, 21202 USA Funera 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2½ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 X Yes 2 □ No ò Specify: 3X Widowed 4 ☐ Divorced Spaniard White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Teacher Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Salvador Jaime Pedro Rico Janine 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jacques Jarman/Son 18816 Liberty Mill Rd., Germantown, MD. 20874 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removal from State ¹ 4 □ Donation 5 □ Other (Specify) Metropolitan Crematory 11/2/2004 Alexandria, Virginia 22. Name and Address of Facility DeVol Funeral Home 21. Signature of Funeral Service Licensee 10 East Deer Park Dr., Gaithersburg, MD. 20877 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Septic Onset and Death **Physician** day /Medical Due to (or as a consequence of): **Examiner** RUMON Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last Examine Hospital or Attanding Physician: The law requires that the death certificate be executed physician and s the burial-transit Due to (or as a consequence of): Box 68760 Physician/Medical attending p for use as IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No 4☐Pregnant at time of death Month Day Year 5 Other (specify) P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 Yes 2 No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Division of Vital 2 No 1 ☐ Yes 2 ☐ No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification; To this 28a. Date of Injury (Month, Day Year) 27. Manper of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Injury 1 Natural 5 Pending after death. investigation 2 Accident 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours at To the Funeral D completely filled i 1 🗹 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature an tine of certifier 29c. License number 29d. Date signed (Month, Day, Year) November 2, 2004 D56652 MO 30. Name and ad ress of person who completed cause of death (Item 23a) (Type, Print) Pofferro H, MO Medical center A-ive Rockville, MD Matthew 9901 31. Date filed (Month, Day, Year) 32. He istrar's Signature State 03 2004 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 00 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Carroll Hospital Westminster Carroll If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Nov 23, 19 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours Min 262 24 1995 1 🗆 M XXF Yrs. 80 1923 Keywest, Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "netural", or Items 23a or 28e-1 show any injury or other traumatic event, the Medical Examinar must be multipled at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No XX Director Maryland Westminster Carroll 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 3830 Baker Road 21157 United States Be Completed by Funeral Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status ☐Yes 2 XXO f Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√√No Specify: Specify: White 3 X Widowed 4 □ Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Secretary US Government 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Frazier Rory Jones Anna Manilla Freeman 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Jeanne J. Milam (Daughter) 2906 Silver Hill Ave, Baltimore, Maryland 21207 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Mathod of Disposition

1 → Burial 2 → Cremation 3 → Removal from State Cedar Hill Cemetery Nov 4, 2004 Suitland, Maryland ¹ 4 □ Donation 5 □ Other (Specify) 22. Name and Address of FacilityLee Funeral Home, Inc 6633 01d 21. Sign ture of Funeral Service Licensee Alexandria Ferry Rd, Clinton, Maryland 20735 mo0257 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) MYOCAVAIAI Pnysician /Medical Due to (or as a consequence of): **Examiner** Phermoniz Sequentially list conditions, if any, leaving to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Que to (or as a consequence of) Examiner and Il-transit The law requires that the death certificate be executed Due to (or as a consequence of): physicien ar Division of Vital Records, P.O. Box 68760. Physician/Medical use as IF FEMALE 23c. If yes, outcome of pregnancy
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2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical

State Registrar 31. Date filed (Month, Day, Year) NOV 03 2004

Stours

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifie

295

westminster

29c. License number

00059943

john

29d. Date signed (Month, Day, Year)

November 1,

2004

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Dav Year George Melvin Kesecker /Medical 09, November 2004 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Memorial Hospital CUMBERLAND ALLEGANY 5. Social Security Number Hours Min. 8. Date of Birth (Month, Day, Year) **Funeral** 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Days **X**□M 2□F Months WD MD Director 220-10-9276 84 Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 28e-f show 10d. Inside City Limits treumatic event, the Medical Examiner must be notified at MD Allegany Cumberland Director V☐Yes 2☐No the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Items 23e 219 Wempe Drive 21502 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. snt: If item 27 is marked other then "naturel", or iter 1 ☐ Yes 2 ☐ No IXYes, Give Year or Dates: WWII 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: white 3€ Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) 2+ Elementary/Secondary (0-12) 12 Road Foreman Railroad 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Sumame) George Melvin Kesecker Edna Adams Kesecker ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Karen Miller 7376 Bedford Valley daughter Bedford PA 15522 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages Department of I Importent: If it any injury or o 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 11/12/2004 Cumberland Sunset Memorial Park 4 ☐ Donation 5 ☐ Other (Specify) MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Scarpelli Funeral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 23a. Part1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** CARDIOGENIC SHOCK days /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause, Unsease or injury that initiated events Examiner Due to (or as a consequence of): use as the burial-transit or Attending Physician: The law requires that the death certificate be execu resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy

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2 Medice Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical To the 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year)

Registrar

State

Vik Poonai M.D. 924 Seton Drive Cumberland, Maryland 21502

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

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NOVEMBER / , 2004

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Work? Second Continue Cont	Vita	certific	Be	examiner?	Other	
28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Nu City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Nu City or Town, State) 29a. Certifier (Check only one) 29a. Certifier (Check only one) 29b. Signature and title of certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 111 Proportion, Point of the print of the p	ot	Phys	-	27. Manner of Death 28a. Date of Injury 28b. Ti	A Notice of Hesidence of Control (Specify)	-
29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause of my knowledge, death occurred at the time, date and place, and due to the cause of my knowledge, death occurred at the time, date and place, and due to the cause of my knowledge, death occurred at the time, date and place, and due to the cause of the cause of my knowledge, death occurred at the time, date and place, and due to the cause of my knowledge, death occurred at the time, date and place, and due to the cause of my knowledge, death occurred at the time, date and place, and due to the cause of my knowledge, death occurred at the time, date and place, and due to the cause of my knowledge, death occurred at the time, date and place, and due to the cause of my knowledge, death occurred at the time, date and place, and due to the cause of my knowledge, death occurred at the time, date and place, and due to the cause of my knowledge, death occurred at the time, date and place, and due to the cause of my knowledge, death occurred at the time, date and place, and due to the cause of my knowledge, death occurred at the time, date and place, and due to the cause of my knowledge, death occurred at the time, date and place, and due to the cause of my knowledge, death occurred at the time, date and place, and due to the cause of my knowledge, death occurred at the time, date and place, and due to the cause of my knowledge, death occurred at the time, date and place, and due to the cause of my knowledge, death occurred at the time, date and place, and due to the cause of my knowledge, death occurred at the time, date and place, and due to the cause of my knowledge, death occurred at the time, date and place, and due to the cause of my knowledge, death occurred at the time, date and place, and due to the cause of my knowledge, death occurred at the time	lon	nding tth. :: Afte e fune	atior	A Natural		
29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause of my knowledge, death occurred at the time, date and place, and due to the cause of my knowledge, death occurred at the time, date and place, and due to the cause of my knowledge, death occurred at the time, date and place, and due to the cause of the cause of my knowledge, death occurred at the time, date and place, and due to the cause of my knowledge, death occurred at the time, date and place, and due to the cause of my knowledge, death occurred at the time, date and place, and due to the cause of my knowledge, death occurred at the time, date and place, and due to the cause of my knowledge, death occurred at the time, date and place, and due to the cause of my knowledge, death occurred at the time, date and place, and due to the cause of my knowledge, death occurred at the time, date and place, and due to the cause of my knowledge, death occurred at the time, date and place, and due to the cause of my knowledge, death occurred at the time, date and place, and due to the cause of my knowledge, death occurred at the time, date and place, and due to the cause of my knowledge, death occurred at the time, date and place, and due to the cause of my knowledge, death occurred at the time, date and place, and due to the cause of my knowledge, death occurred at the time, date and place, and due to the cause of my knowledge, death occurred at the time, date and place, and due to the cause of my knowledge, death occurred at the time, date and place, and due to the cause of my knowledge, death occurred at the time, date and place, and due to the cause of my knowledge, death occurred at the time, date and place, and due to the cause of my knowledge, death occurred at the time, date and place, and due to the cause of my knowledge, death occurred at the time	N N	r Atter ter dea irector irector	rtifica	3 Suicide 6 Could not be 28e. Place of Injury - At home, farr	m, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State)	
A 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 111 Prop. Street Politimore Maryland 2126	Δ .	pital c		20g Codfier 1 Cartifying Physician: To the hest of my knowledge	death occurred at the time, date and place, and due to the cause(s) and manner as stated	
A 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 111 Prop. Street Politimore Maryland 2126	:	ne Hos n 24 ho na Fun oletely	edica	(Check only 2 Medical Examiner: On the basis of examination and		
A 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 111 Prop. Street Politimore Maryland 2126		To the To the comp	ž		29c. License number 29d. Date signed (Month, Day, Year)	
111 Down Chroat Politimore Maryland 2120	0					
111 Telli ottect, buttinote, rangitud 2120	K			30. Name and address of person who completed cause of death (Item 23a) (T	111 Penn Street, Baltimore, Maryland 21201	
State Registrar 31. Date filed (Month, Day, Year) 2004 . Registrar's Signature				31. Date filed (Month, Day, Year)	hade	

		•	State of Maryland / Department of Health ar 1- State State State of Maryland / Department of Health ar Certificate of Death	nd Men		2004	36622
	Physicia		Decedent's Name (First, Middle, Last) JEANNE RUTH LONSBURY		Date of Death Month TOBER	31, 2004	3. Time of Death 4:40 P. M
	/Medic Examin		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of			4c. County of De	ath
			7011 Wood Thrush Drive Lanham 5 Social Security Number 6 Sex 7 Age (In yrs. last birthday) If Under 1 Year If Under 2	14 Mea -		Prince (
	Funeral Director		5. Social Security Number 270–26–3097 6. Sex 1 \square M 2 \square F 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Months Days Hours	Min. Ju	Date of Birth Month, Day, Y uly25 , 1	930	irthplace (State or Foreign Pountry) hio
	and bw		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits
	Mary a-f sho	tor	Maryland Prince George's Lanham				1 ☐ Yes 2 X No
	with the	al Director	7011 Wood Thrush Drive 10f. Zip Code 2070)6		. Citizen of What (Inited St	
36	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Executes traumatic event, the Medical Executes traumatic event, the Medical Executes traumatic event, the Medical Executes the rediffical at	by Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Original If Yes, specify Cuban, Mexican, 1 □ Yes 2 ☑ No Specify:	in? (Specify Puerto Rica	Yes or No- in, etc.)	14. Race - An Black, Wh Specify:	
Maryland 21215-0036	within 72 hou ene. then "natura ne Medical E	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	of working		b. Kind of Busines	
2	filed w Hygier other th		12 1-4 Teacher 17. Father's Name (First, Middle, Last) 18. Mother's	's Name (Fir		Educatio	n
ylan	2 should be and Mental lis marked or raumatic evs	To Be	Bernard Rosicker Emily	7			Majka
	and 2 sh alth and 127 is m er traum		19a. Informant's Name/Relationship (Type, Print) Thomas Albert Lonsbury —Husband 19b. Mailing Address (Street and Number 7011 Wood Thrush D				
Baltimore,	ges 1 and 2 of Health if Item 27		20a. Method of Disposition 1XX urial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Cate of Heaven Cemetery	Date 7 11 / /		c. Location - City of	
Itim	permit. Pages 1 Depertment of P Important: If Ite any Injury or on		'4 Donation 5 Other (Specify)				
Ba	Depermination of the police of		Worold & Bargewart 4400 Powder Mill	L Road	Pelts	<i>r</i> ille, Ma	ryland 20705
			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as ca shock, or heart failure. List only one cause on each line. Immediate Cause (Final		spiratory arrest		Approximate Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death) a. Advanced Aclero Carcito no Due to (or as a consequence of):	<u> </u>			
	Examiner	_	Sequentially list conditions, Due to (or as a consequence of)				
	uted d ansit	Examiner	Sequentially list conditions, Larry Learner Underlying Cause (Disease or injury that initiated events c.				
ő,	cate be executed physician and the burial-transit		resulting in death) Last Due to (or as a consequence of):				
68760	icate b physic s the b	dlcal	d				
.O. Box (that the death certific ed by the attending p detached for use as t	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1			23d. Date of d Month	elivery Day Year
<u>α</u>	requires that the been signed by th hould be detache	by Ph	Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I.		23e. Did tobac	cco use contribute	to the cause of death?
ords	v require been sig should b				1 🗆 Yes	2 X No 3□1	Probably 4 □Unknown
Vital Records,	The law ate has t page 2 s	Completed			24a. Was an autopsy performed 1 ☐ Yes 2 ☑	prior to	
Vita	Physiclan: Tribis certificateral director, p.	Be	examiner? Hospital: Other		neck only one)		
o		lon; To	27. Manner of Death 1 Inpatient 2 EH/Outpatient 3 DOA 4 Nurs 27. Manner of Death 1 X Natural 5 Pending (Month, Day Year) 1 X Natural 5 Pending (Month, Day Year)	28d.		e 6 Other (Sp injury occurred	ecify)
Division	at at	Certification;	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. l	Location (Stree City or Town, S		Rural Route Number,
J	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune		29a. Certifier (Check only (Ch				
	To ths within 2 To ths complet	Medical	one) and manner stated. 29b. Signature and title of certifier 29c. License number		29d	. Date signed (Moi	nth, Day, Year)
			1 Pail # 20 D60812	_	N	lovember	2, 2004
	18		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) R L Giwrel: I no 600 N. Wolfe St., #281 Baltimore	, Mary	yland 2	1287–128 ⁻	
	Sta Registi		31. Date filed (Month, Day, Year) NOV 03 2004 32. Begistrar's Signature Sports				

			For State Registrar		State of	f Marylar		artmer <i>rtifica</i> i				lental Hy	giene (004	36623
	Physici		1. Decedent's Name (First, MADELINE S.		п.т.тктх	ı			-			2. Date of De Month NOV	Day	Year 2004	3. Time of Death 6:40 A ^M
	/Medic Examir		4a. Facility Name (If not insti	tution, give s	treet and nur	nber)		_		Location	of Death	NOV		inty of Death	n
	Funeral		Genesis Heats. Social Security Number	6. Sex		- The 7. Age (In yrs.		If Unde Months		ton If Under	24 Hrs.	8. Date of Bir (Month, Da JAN 11	th (V Year)	Talb	Ot nplace (State or Foreign untry)
	Director		220-03-2372 Usual Residence of Deceder		м 2 X О F	88	Yrs.	WOTHIS	Days	Hours	IVIII.	JAN TT	1916		RYLAND
	yland how		10a. State 10b. Co			10c. C	ity, Town or Lo	ocation							10d. Inside City Limits
	he Mar	Director		TALBOT			EAS'		Code				10g. Citizen	of What Co	XX Yes 2 □ No
	3a or 3	Dir	10e. Street and Number 610 DUTCHMA	NS TAN	IE.			101. 21		1601			TOG. CITIZETT	USA	-
	oms 2	Funeral	11. Marital Status			dent Ever in U	J.S. 13.	Was Dece			igin? (Sp	ecify Yes or No Rican, etc.)	- 14. i	Race - Amer Black, White	
900	is it is a supposed with the Maryland within 72 hours after deeth with the Maryland lene. I then "natural", or items 23s or 28s-1 show ite Medical Examines frontified at	by Fu	1 ☐ Never Married 2 ☐ 3 ☐ Widowed 4 ☐ Divo		1 ∐Yes If Yes, Giv Year or Da	2/ XNo		1 ☐ Yes		Specify:		,,			IITE
n	72 ho	eted	15. Dec (Specify only h	edent's Educ	ation completed)		16a. Dece (Give	dent's Usu kind of we DO NOT L	al Occupa	ation during mos	st of work	ing	16b. Kind o	f Business/l	ndustry
iki		Completed	Elementary/Secondary (0-	12)	College (1	-4or 5+)	iiī e.		MEMA				OWI	и номе	
	othe othe	Be C	17. Father's Name (First, Min	ddle, Last)						18. Moth	er's Name	e (First, Middle,	Maiden Sun	name)	
Mull	should be and Mental i marked o	To	ROLAND SARD 19a. Informant's Name/Rela		o Printl		10b Mailie	no Addras	(Stroot			IA TALLE		um Stato 7	in Code)
ine	S S S S S S S S S S S S S S S S S S S		KENNETH E. M									ASADENA			ip C00e)
11	7 00		20a. Method of Disposition 1 Burial 2 □ Crema			- 1	Place of Dispo cemetery, crea	sition (Na matory or	me of other plac	θ)	t	Date	20c. Location	on - City or T	Town, State
Madeli	permit. Pag Department Important: I any injury o		'4 □Donation 5 □Oth	er (Specify)				MEMO				-8-2004	EAS.	ron, M	IARYLAND
M	permit. Departmit mports any inju		21. Signature of Funeral Ser	Rice License		CER	F	ELLOV	IS, H	ELFE	MBEIN	& NEWN EASTON,	NAM FUI	NERAL 1601	HOME PA
	Physician		23a. Part1. Enter the diseas shock, or heart failure. Immediate Cause (Final disease or condition	se, or complic List only on	cations that co	aused the dea ach line.	th. Do not ent		de of dyin	g, such as					Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death)	(a	Due to	or as a consex	quence of):	or ju							7
	LAMITHIE	F	Sequentially list conditions, if any, leading to immodiate cause. Enter Underlying	b.	Dua to (or as a consec	quence ut):								years
	cuted nd ransit	Examiner	that initiated events	c.											
9	death certificate be executed death certificate be executed e attending physicien and of or use as the burial-transit		resulting in death) Last		Due to (or as a consec	quence of):								
100	ificate ificate g physi	edicai		, d.											
03203	leath certifical attending phy	an/M	IF FEMALE: 23b. Was decedent pregnar in the past 12 months?	nt l		come of pregn	al death 3	Ectopic p						Date of delive	very Day Year
	at the dea by the at	Physician/Med	1 ☐ Yes 2 ☐ No 9 ☐ Unknown		4□Pregn 9□Unkno	ant at time of o	death 5	Other (s	pecify)					WORL	Day
2	The law requires that the steep by the page 2 should be detached.	by Ph	Part II. Other significant con		4	ath but not res	sulting in the u	nderlying (ause give	n in Part I	l.	23e. Did to	obacco use c	ontribute to	the cause of death?
	w requires been signal should be	ted t	A /zkeimer	i dem	ng pan							1 🗆 \	res 2□No	3 🗌 Pro	bably 4 Unknown
6	has by	Completed	Thou do	firsen le	1 ann	ma						24a. Was autop perfo		prior to death?	opsy findings available ompletion of cause of
-	ician: The l	a l	25. Was case referred to me	edical						26. Place	e of Deatl	1 ☐ Yes	25X No	1 🗆 Yes	2 No
2	Physician: rthis certificaral director, particular	To B	examiner?	Н	-		ER/Outpatier			or: NO	ursing Ho	me 5□Resid	dence 6 🗆		ify)
3	ding Ph th. After thi funeral	tion:		ending vestigation	28a, Date of (Mont	of Injury h, Day Year)	28b. Time of Injury	f M	28c. Injury Work 1 □ `	rat :? Yes 2 □		28d. Describe h	now injury occ	curred	
O o openion of Wish	To the Hospital or Attending within 24 hours after death. To the Funarel Director: After completely illed in by the funarel	Certification:	3□ Suicide 6□C	ould not be etermined	28e. Place buildir	of Injury - At h	nome, farm, str	eet, factor				28f. Location (S City or Tox	Street and Nu vn, State)	mber or Rui	ral Route Number,
C	To the Hospital or within 24 hours after To the Funerel Direction Completely filled in E		29a. Certifier 1 Cer	tifvina Phys	icien: To the	hest of my kn	owledge deat	b occurred	at the tim	e date an	nd place	and due to the	rausa(s) and	manner as	ctated
	ne Hos n 24 ho ne Fun	edical	(Check only 2 Med one)	dical Examin	er: On the ba	asis of examina	ation and/or in	vestigation	i, in my or	pinion, dea	th occurr	ed at the time,	date and plac	e, and due	to the cause(s)
	To the within To the comp	M	29b. Signature and title of ce	ertifier	m	2007		29	c. License	number	022		29d. Date sig	ned (Month	, Day, Year)
			20 Name and address of a	rean who say	MARC maleted source	of death ()	My 232) (Tuna	Print)	U	YUD	127		11'7	UT	
			MICHREL	ROWLE	Y M	5	08 T	, ,	WILI	o F	VEN	UE E	ASTON	MM	21601
U	Sta Regist	ate rar	31. Date filed (Month, Day,	Year)	32. R	egistrar's Sign	ature day	M.							

			1- For State of Maryland / Department	artment of Health and M rtificate of Death	lental Hygier Reg. 1	2004 36624
ï			Decedent's Name (First, Middle, Last)		0.0 (0	
	Physici /Medic		John F. Morina, Sr.		October	30 2004 11:20 P M
	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death
			1642 Addison Rd., S	Forestvill		Prince George's
Н	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 577−50−3818 1. 9 M 2 □ F 67 Yrs.	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Yea March 29,	9. Birthplace (State or Foreign Country)
	Director		Usual Residence of Decedent	f	march 29,	1937 Wash., DC
	yland now		10a. State 10b. County 10c. City, Town or Lo	cation		10d. Inside City Limits
	Mar-fish	tor	Maryland Prince George's	Forestville		1. Yes 2 □ No
	or 28	Director	10e. Street and Number	10f. Zip Code	10g. (Citizen of What Country?
	23a		1642 Addison Rd., S.	20747		United States
	r deg	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Agmed Forces?	Was Decedent of Hispanic Origin? (Spe f Yes, specify Cuban, Mexican, Puerto F	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc.
36	or it	by Fu	1 □ Never Married 2 □ Married 1 ♣ Yes 2 □ No If Yes, Give 3 □ Widowed 4 ♣ Divorced Year or Dates:	1 ☐ Yes 2 No Specify:		Specify: Black
21215-0036	tiled within 72 hours after death with the Maryland Hygiene. other than "naturel", or Items 23a or 28a-1 show ant, the Medical Examinar must be notified at	ed b		dent's Usual Occupation	16b	Kind of Business/Industry
7.	n "na	Completed	(Specify only highest grade completed) (Give	kind of work done during most of workir DO NOT use retired)	ng Tob.	Tand or business moustry
212	d with giene.	mo	Elementary/Secondary (0-12) College (1-4or 5+) Gian	t Food Employee		Private
힏	al Hygory otha	Bec	17. Father's Name (First, Middle, Last)	18. Mother's Name	(First, Middle, Maide	en Sumame)
<u> a</u>	Ments Ments arkad	To	John Morina		Lucille	Price
Maryland	and and ls my		19a. Informant's Name/Relationship (Type, Print)	ig Address (Street and Number or Rura)	l Route Number, City	or Town, State, Zip Code)
2	and lealth m 27 har tr			1642 Addison Rd.,		
Baltimore,	ges it of H		1 XBurial 2 Cremation 3 Removal from State	natory or other place)		Location - City or Town, State
Ħ	it. Partmer			Veterans Cem. 11/4 Name and Address of Facility St		heltenham, MD
Bal	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is merked other than "natural", or items 23a or 28a-f show any figury or other traumatic evant, the Medical Examination at a once.			4001 Benning Rd.,		
		_	23a. Part1 Enter the disease, or complications that caused the death. Do not enter	-		Approximate
			shock of heart failure. List only one cause on each line.	, •		Interval Between Onset and Death
	Pnysician /Medical		disease or condition resulting in death) Cancer of Par Due to (or as a consequence of):	ncreas		
	Examiner					
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Disease or hour.			
	cuted nd ransii	Examiner	that initiated events			
Ó,	e exe ian a urial-i	EX	resulting in death) Last Due to (or as a consequence of):			
8760,	ficate be executed physician and is the burial-transit	dicai	d			
	entific ding p	/Me	IF FEMALE:			
P.O. Box	that the death certificated by the attending properties as	Physician/Me		Ectopic pregnancy Other (specify)		23d. Date of delivery Month Day Year
o.	he de	ysic	1 Yes 2 No 9 Unknown	Other (specify)		
	The law requires that the death certifi te has been signed by the attending bage 2 should be detached for use as	y Ph	Part II. Other significant conditions contributing to death but not resulting in the un	iderlying cause given in Part I.	23e. Did tobacco	use contribute to the cause of death?
Records,	luires n sigr	d by			1 ☐ Yes	2 X No 3 ☐ Probably 4 ☐ Unknown
Ö	w require s been sign should b	lete			24a. Was an	24b. Were autopsy findings available
Re	The la te has age 2	Completed			autopsy performed?	prior to completion of cause of death? o 1 ☐ Yes 2 ☐ No
Vita		0	25. Was case referred to medical	26. Place of Death		0 10165 20160
<u> </u>	> . <u>v</u> 0	To B	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient	3 □ DOA Other: 4 □ Nursing Hom	ne 5 X Residence	6 Other (Specify)
0			27. Manner of Death 1	28c. Injury at 28 Work?	8d. Describe how inj	ury occurred
Sio		cati	2 Accident investigation	M 1 ☐ Yes 2 ☐ No		
Division of	I or Attanation after death	Certification:	3 Suicide 6 Could not be 4 Homicide determined 28e. Place of Injury - At home, farm, stre building, etc. (Specify)	et, factory, office	8f. Location (Street a City or Town, Sta	nd Number or Rural Route Number, re)
	pital urs a aral D	Ce	Constitution Distriction To the heat of multipopulation of selections			
	Hos 24 ho Fun stely (edical	29a. Certifier (Check only one) 2 ☐ Medical Examiner: On the basis of examination and/or invone)	estigation, in my opinion, death occurre	nd due to the cause(: d at the time, date ar	s) and manner as stated. Indicate, and due to the cause(s)
	To the Hospital or At within 24 hours after or To the Funaral Dirac completely filled in by	Me	29b. Signature and title of certifier	29c. License number	29d. D.	ate signed (Month, Day, Year)
	->+0			40004588	-1 1	1102104
)	(5)		30. Name and address of person who completed cause of death (Item 23a) (Type, F		,	11-01-
_				ercantile Lane, Upp	per Marlbo	ro, MD 20774-5374
	Sta		31. Date filed (Month, Day, Year) NOV 0 4 2004	<i>a</i> .		
	Registr	ar	HOT U 4 LOUT PLANE AND AND AND AND AND AND AND AND AND AND			

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Albert Frederick Maden /Medical October 30 2004 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Holy Cross Hospital Silver Spring Montgomery If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months 15 M 2 F Director 213-42-3275 60 Virginia Usual Residence of Decedent with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits or Items 23a or 28e-f show the Medical Examiner must be notified at 1 Yes 2 No Director Maryland Montgomery Wheaton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3218 Pendleton Drive 20902 USA 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ⊠Yes 2 □ No
If Yes, Give 1963-69
Year or Dates: 1 ☐ Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: 3 Widowed 4 Divorced White Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filled with Department of Heath and Mental Hygien Important: If item 27 is marked other the any injury or other traumaits 4 Senior Contract Administrator Public Transportation injury or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Not Available Evelyn Norton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3218 Pendleton Drive, Wheaton, MD 20902 of Disposition (Name of Date 20c. Location - City or Christine Penman Maden/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State November 6, Metropolitan * 4 □ Donation 5 □ Other (Specify) 2004 Crematory Alexandria, Virginia 21. Signature of Funeral Service Licens 22. Name and Address of Facility
Francis J. Collins Funeral Home Inc. Will Edd 500 University BLvd, W, Silver Spring, MD 20901 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician LIVER MILLUM disease or condition resulting in death) 2047 /Medical Due to (or as a consequence of): Examiner CAWORL MEMBERRIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner requires that the death certificate be executed burial-transit GASTINIC CANCRA that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, attending physician Physiclan/Medical as the IF FEMALE: use 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 4☐Pregnant at time of death ☐Yes 2☐No detached the 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ ASPINIMIN PHRUDONIA 1 🗌 Yes 2 🗖 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed 1 ☐ Yes 2 ☐ No 1 ☐ Yes al or Attending Physician: after death. I Director: After this certifica 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 0 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Tyeş 2 ER/Outpatient 3 DOA funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Matural 5 Pending 2 Accident investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours ar Hospital 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) To the I 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D17368 2+1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 20902 Schwartz, Medical Park Dr. MD 2101 31. Date filed (Month, Day, Year) 32. Registrar's Signature 03 NOV Registrar

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	E		1. Decedent's Name (First, Middle, Last)					2. Dat	e of Death	Day Year	3. Time of Death
	Physici /Medic		Florence J. Malc	olm							9, 2004	4:10 PM
	Examin	er	4a. Facility Name (If not institution, give	street and number)		4b. City,	Town, or	Location of	f Death	4	4c. County of Dea	th
			5 Byford Court 5. Social Security Number 6. Se	y 7 Ar	je (In yrs. last birthd			rtown	2.11	e of Birth	Kent	thplace (State or Foreign
Н	Funeral Director		156-22-2330	ÎM 2□F '````	75 Yrs	Months	Days	Hours	Min. (Mo	nth, Day, Yea	ar) Co	ountry)
	D		Usuel Residence of Decedent	Δ.					sep	t. 6,	1929 Vi	rginia
	arylan show	_	10a. State 10b. County		10c. City, Town or	Location						10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	88-1-8	octo	Maryland Kent		Cheste							X
	with ti	Dire	10e. Street and Number			10f. Zip		• •		10g. C	Citizen of What Co	ountry?
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21215-0036	permit. Peges 1 and 2 should be filed within 72 hours efter death with the Maryland Depertment of Health and Mental Hygiene. Important: if Item 27 is marked other than *natural; or Iteme 23a or 28a-f ehow any injury or other traumatic event, Ite Medical Explainer must be notified at ance.	by Funeral Director	1 Never Married 2 Xarried 3 Widowed 4 Divorced	Armed Forces? 1 Yes 2 If Yes, Give Year or Dates:		If Yes, spec	77	n, Mexican, Specify:	jin? (Specify Ye , Puerto Rican, e	etc.)	Black, Whit	
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7	lled w tygiei ther ti	S	12 17. Father's Name (First, Middle, Last)	4	Hom	emaker		18 Mother	r's Name (First,		vn Home	
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<u> </u>	Should Me Merit	ဥ	19a. Informant's Name/Relationship (T		19b. M	ailing Address	(Street a				y or Town, State. 2	Zip Code)
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nore,	eges 1 a int of He t: if item y or othe		20a. Method of Disposition 1 Burial 2 remation 3 4 Donation 5 Other (Specify,		20b. Place of Dis	position (Namerematory or o	ne of ther place	a)	Date 10/30/20	20c.	Location - City or cevensvil	Town, State
Baltimore,	permit. P Depertme Importen any injuri ance.		21. Signature of Funeral Service Licens		1	22. Name an	d Addres	s of Facility	130 Sr	eer Rd	l. Cheste	ertown, MD Hm. P.A.
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	Physician		Immediate Cause (Final disease or condition	a. NEP	atic (Caro		om	-			Interval Between Onset and Death
ſ.	/Medical Examiner		resulting in death)	Due to (or as	a consequence of):							
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S, P.	signed by	y Ph	Part II. Other significant conditions co	ntributing to death b	out not resulting in the	underlying c	ause give	n in Part I.	236	. Did tobacço	use contribute to	the cause of death?
rds	w require: been sig should by									1 🗌 Yes	2 No 3 □ Pr	obably 4 Unknown
Vital Record	Physician: The law requires that the rthis certificate has been signed by th rail director, page 2 should be detach	Completed			416					a. Was an autopsy performed? Yes 2 N	prior to d	stopsy findings available completion of cause of
/ita	Physician: this certifica rai director, p	BeC	25. Was case referred to medical examiner?						of Death (Check			
of \	Physic this crail dire	၉	TLI Yes ZLINO	Hospital: 1 Inpatio				4 Nur	-		6 □Other (Spec	cify)
n C	of or Attending Patter death. Director: After to in by the funera	lon	27 Manner of Death Natural 5 Pending	28a. Date of Inju (Month, Da	ury 28b. Time ly Year) Injur		8c. Injury Work	at :? /es 2 □ N		scribe how inj	jury occurred	
Division	Attending r death. ector: After by the fune	lical	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of In	jury - At home, farm,				28f. Loc	ation (Street a	and Number or Ru	ıral Route Number,
<u>S</u>	s after ei Dire ed in by	Certification:	4 Homicide determined	building, et	tc."(Specify)				City	or Town, Sta	ite)	
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ł	To the within 2 To the complete	Σ	29b. Signature and title of certifier	My		290	License	number 05	1786	29d. D	ate signed (Month	n. Day, Year)
			30. Name and address of person who co	ompleted cause of c	death (Item 23a) (Typ		ا ا	Pelo	Ches	terto	m Mi	2120
	Sta Registi		31. Date filed (Month, Day, Year) NOV 0 3 2004	32. Registr	rar's Signature							
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			For State Registrar	State of Marylan		artment of H				4 36627
E	Physicia		Decedent's Name (First, Middle, Last) Mary Louise	e Maryanov				2. Date of Dea Month Octobe	ath Day Ye	3. Time of Death 1810 M
	/Medic Examin		4a. Facility Name (If not institution, give s			4b. City, Town, or	Location of Deat		4c. County of t	
			DORCHESTER GENE			CAMBR				CHESTER
	Funeral Director		5. Social Security Number 6. Sex 120–10–9870	M 2 F 7. Age (In yrs. I	last birthday, Yrs.	Months Days	If Under 24 Hrs Hours Min.	8. Date of Birt (Month, Day June 2.	3, 1917	Birthplece (State or Foreign Country) Pennsylvania
	pug A	-	Usual Residence of Decedent 10a, State 10b, County	10c. City	y, Town or L	ocation				10d. tnside City Limits
	e-f eho	ctor	MD Dorches				ridge			1° XYes 2 □ No
\mathcal{Z}	or 28	Dire	10e. Street and Number			10f. Zip Code	24.54.2		10g. Citizen of Wha	•
3	s 23a	ral	300 Somerset Ave	Was Decedent Ever in U.	C 13	Was Decedent of Hi	21613	inecify Yes or No-	U.S.A	• American Indian,
936	be filed within 72 hours after death with the Maryland tall Hygiene. id other than "natural", or items 23a or 28e-f ehow event. The Medical Examiner must be notified at	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced	Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	0. 10.	Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2 No	n, Mexican, Puer Specify:	to Rican, etc.)	Bleck, \ Specify:	White, etc. white
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	12 s h ar 7 is trau		Carol Ann Williams	on daughter	300	Somerset		ambridge,	MD 216	13
Baltimore,	Pages 1 and nent of Heath int: If item 2 iny or other		20a. Method of Disposition 1°⊠Burial 2 ☐ Cremation 3 ☐ Re	emoval from State	emetery, cre	osition (Name of matory or other place	1	Date /29/04	20c. Location - City	
Ē	nit.		* 4 □ Donation 5 □ Other (Specify) 21. Signatur 11 Funeral Service License		the second second second	cy Churchy 2. Name and Addres		and the second s	Church Ci ineral Hor	
Ã	Den Person		I John Tolon	-		700 Locust				
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.O. Box 687	The law requires that the death certificate to the law requires that has been signed by the attending physicage 2 should be detached for use as the last.	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 \(\text{Yes} \) 2 \(\text{No} \) 9 \(\text{Unnown} \) Unknown	3c. If yes, outcome of pregna 1 Live birth 2 Feta 4 Pregnant at time of d	Ideath 3	□Ectopic pregnancy			23d. Date o Month	f delivery Day Year
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ion of	Attending Physical death. ctor: After this y the funeral di		27. Manner of Death Astural 5 Pending Accident investigation	28a. Onte of Injury (Month, Day Year)	28b. Time o Injury	Worl	vat <br Yes 2 □ No	28d. Describe h	now injury occurred	
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	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: Attencompletely filled in by the funer	Medical C	29a. Certifier (Check only one) Certifying Physical Examination (Check only one)	sician: To the best of my kno nar: On the basis of examina and manner stated.	wledge, dea tion and/or I	th occurred at the time nvestigation, in my of	ne, date and place pinion, death occ	e, and due to the durred at the time,	cause(s) and manne date and place, <i>a</i> nd	er as stated. due to the cause(s)
2	To the within 2 To the comple	Me	29b. Signature and title of certifier	11		29c. License	number		29d. Date signed (A	fonth, Day, Year)
			· lugere 1	(ewa)		175	1793		10/26	104
			30. Name and address of person who co	mpleted cause of death (Iten	n 23a) (Type	, Print)	3	+ C.	amba d	MO 2/13
	Sta	te.	31. Date filed (Month, Day Year)	32. Registr ø 's Signa	iture		J'm		CHANGE CONT.	0/0/5
	Registr		001 2 8	ZUU4 Decem	o Js.	frought.				

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 2. Date of Death 1. Decedent's Name (First, Middle, Last) Oct. Day **Physician** 29, 2004 7:00 a M Nwachukwu Ignatius /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince Georges 7006 Hanover Parkway #C2 Greenbelt | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | Nov • 2, 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1₩ 2□F 1950 Yrs Nigeria 228-61-2285 53 Director Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10c. City, Town or Location iral, or Items 23s or 28a-f show Examiner number notified at 14 Yes 2 No Directo Prince Georges Greenbelt Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 7006 Hanover Parkway 20770 Nigeria Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 Never Married 2 Married Specify: Black Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ 3 Widowed 4 Divorced Year or Dates: 'natural', leted 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Corrections Officer 16b. Kind of Business/Industry event, the Medical 15. Decedent's Education (Specify only highest grade completed) Dept. of Corrections Compl Elementary/Secondary (0-12) College (1-4or 5+) 5+ other than 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Virginia Okoro la marked John Nwachukwu item 27 la ma 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7006 Hanover Pkwy. #C2 Greenbelt, Md. 20770 Fidelia Nwachukwu (Wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 'Department of H Important: If ite any Injury or ot 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Nov. 21, 2004Port Harcourt, Nigeria Family Cemetery * 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility W. H. Bacon Funeral Home, Inc. 3447 14th St., N.W. Washington, D.C. 20010 21. Signature of Funeral Service L anda 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Carcinoma Of The Stomach With Widespread Metastasis **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. the attending physician Physiclan/Medical as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 4 Pregnant at time of death 5 Other (specify) Yes 2 No 9 Unknown 9 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ▼No 3 ☐ Probably 4 ☐ Unknown Pleural Effusion Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? 1 ☐ Yes 2 ☐ No 1□ Yes 2√2 No Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ER/Outpatient P 1 Yes 2 XNo 3□ DOA After this 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural 2 Accident 1 Yes 2 No after death 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. Within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of 29c. License number Nov. 4, 2004 D0052883 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Oliver M. Bennett. 1111 Spring St., #G1 Silver Spring, Md. 20910 M.D. State 0 4 2004 NOV Registrar

			For State Registrar	State	of Maryland /	Depa Ce	artment of Hertificate of L	ealth an D <i>eath</i>	nd Menta	l Hygie	Z (04	366	29
	0,		1. Decedent's Name (First, Middle	e, Last)						of Death			3. Time of	Death
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	Examin		4a. Facility Name (If not institution	n, give street and nu	ımber)		4b. City, Town, or	Location of D		1		unty of Deat		
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	Funeral		5. Social Security Number	6. Sex	7. Age (In yrs. last b	inthday)	If Under 1 Year	If Under 24		of Birth		9. Birtl	nolace (State o	or Foreign
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<u></u>	of in a general section of the secti		1 Burial 2 Cremation		State Cemete	ery, cren	natory`or other place olitan) No	vember	2	. Locat	on only or i	Own, State	
altimore,	it. Purtue		 4 □ Donation 5 □ Other (S_i 21. Signature of Funeral Service I 	Liannena	Cr	ema	tory	-4 5111	2004	Ale	exan	dria,	Virgin.	ia
Ba	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.		Nichard	I Hate	2	F.	Name and Address rancis J. 00 Univers	Colli	ns Fune	eral H	Iome	Inc.	- MD 0	0001
			23a. Part1. Enter the disease, or								er	Spring	Approximate	
ı	-		shock, or heart failure. List Immediate Cause (Final	only one cause on	each line.	1101 0111	or the mode of dying	, 30011 03 001	GIAC OF 163PITA	tory arrest,			Interval Betw Onset and D	veen
	Physician /Medical		disease or condition resulting in death)		rstitial I		Disease						6 MOnt	hs
	Examiner			Due to	(or as a consequence	of):								
١.		e	Sequentially list conditions, if any, leading to immediate	b. — Due to	(or as a consequence	of):								
	petr insit	E I	cause. Enter Underlying	S		,								
	al-tra	Examiner	that initiated events resulting in death) Last	c. Due to	(or as a consequence	of):								
8760,	cate be executed physician and the burial-transit	dlcal										ľ		
89				0.										
ŏ	death certif e attending ad for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant		tcome of pregnancy						23d	Date of deliv	90/	
m	death atte	Cla	in the past 12 months? 1 □ Yes 2 □ No		oirth 2 🗌 Fetal deatl nant at time of death		Ectopic pregnancy Other (specify)					Month		ear
0	the oy the ache	hys	9 Unknown	9□ Unkn	own									
	The law requires that the death certif te has been signed by the attending age 2 should be detached for use a.	by P	Part II. Other significant condition	ns contributing to d	eath but not resulting	in the ur	derlying cause giver	n in Part I.	23e.	Did tobacc	o use c	ontribute to t	he cause of de	ath?
Records,	quire in sig uld b		Chronic Obstruc	tive Pu	lmomary Di	seas	e			1 🗌 Yes	2 √ No	3 Proi	bably 4 □Ur	nknown
00	w require s been si should b	lete			-				24a	Wasan	24	b Were auto	opsy findings a	vailable
Z E	The lav	Completed		·					-	autopsy performed	?	death?	impletion of ca	use of
<u>ra</u>		Ü .	25. Was case referred to medical					00 Dia		Yes 213x	No	1 🗆 Yes	2 No	
>	Physician: rthis certifica ral director, p	0 0	examiner? 1 \(\sum \) Yes 2 \(\omega \) No	Hospital:	Inpatient 2 ER/O	utaationi			Death (Check					277
Division of Vital	<u>a</u> + <u>a</u>	-	27. Manner of Death	28a. Date	of Injury 28b.	Time of	28c. Injury a	at	g Home 5 🗆	Hesidence cribe how in	6 LI	Other (<i>Specii</i> curred	(y)	_
0	ading f th. : After s funer	텵	1 X Natural 5 ☐ Pending 2 ☐ Accident investig	3	th, Day Year)	Injury	Work?	es 2 □No						
<u> S</u>	r Atten er deal rector: by the	i CE	3 ☐ Suicide 6 ☐ Could n	ned 286. Place	of Injury - At home, fa	arm, stre	et, factory, office		28f. Loca	tion (Street	and Nu	mber or Rura	al Route Numb	ΘΓ.
	al or Attendia safter death. Il Director: Al d in by the fu	Certification:	4 Homicide	buildi	ing, etc. (Specify)		•		City	or Town, St	ate)			
	spita hours nera y fille		29a. Certifier 1 ☐ Certifying	g Physicien: To the	best of my knowledg	e, death	occurred at the time	, date and pla	ace, and due t	o the cause	(s) and	manner as s	tated.	
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funeral completely filled in by the funeral completely filled in by the funeral completely filled in by the funeral completely filled in the funeral completely filled in by the funeral completely filled in the fun	Medical	(Check only 2 Medical E	Exeminer: On the b	asis of examination ar ner stated.	nd/or inv	estigation, in my opir	nion, death o	ccurred at the	time, date a	and plac	e, and due to	the cause(s)	
	To the Hospital within 24 hours a To the Funeral C completely filled	ž	29b. Signature and title of certifier				29c. License	number		29d. I	Date sig	ned (Month,	Day, Year)	
	5		Day diluse 1	line-Mo	ullane.		DUOSE	542		307	026	e 31,	ىئەن 1.1	
		-	30. Name and address of person v			(Type, F				301	7 3 2	- 31		
	1													
			DR. LIBUIC HEIN	2- Ma MGIL	JUIC . 115.	oi G	EURGIA A	VELUE	# 515	WHE	ATJ	MIN	D 2090	2
**	Stat	e	DR. LIBUSE HEIN 31. Date filed (Month, Day, Year) NOV 03	32. A	egistrar's Signature	oi G	EURGIA A	くらとこの	# 515	WHE	ATJ	M , M	0 2090	2

			Please		aryland / Depa		Health and M	lental Hyg	iene 2001	36630
75	Physici	an	Registrar 1. Decedent's Name (First, Middle, Last William H. Norris		Cei	runcate or	Dealit	2. Date of Deat Month	3	3. Time of Death
	/Medio	al	4a. Facility Name (If not institution, give			4b. City, Town,	or Location of Death	Novembe	4c. County of Dea	05:52A M
	LXAIIII		Chester River Hos	spital Cer	iter	Chester			Kent	
	Funeral Director		217 20 7102	7. Age	o (In yrs. last birthday) 78 Yrs.	If Under 1 Year Months Days		8. Date of Birth (Month, Day, Sept. 22,		thplace (State or Foreign ountry)
	and land	}	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	ocation				10d. fnside City Limits
	Mary P-f sh	ţō	MD Kent		Chest	ertown				1 ☐ Yes 2 💢 No
	or 28	Director	10e. Street and Number		·	10f. Zip Code		10	0g. Citizen of What C	ountry?
	s 23a	rai	25840 Collins		Constitution 110	2162		andu Van ar Na	USA 14. Race - Ami	odean Indian
220	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Broatchett: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Evantment must be notified at another.	by Funerai	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent I Armed Forces? 1 XYes 2 N If Yes, Give Year or Dates:	10	Was Decedent of If Yes, specify Cub 1 ☐ Yes 2 X No	Hispanic Origin? (Spoan, Mexican, Puerto Specify:	Rican, etc.)	Black, Whi	te, etc.
21213-0030	thin 72 hore. 9. An 'natura Medical B	Completed	15. Decedent's Edit (Specify only highest grad		(Give	DO NOT use retire	during most of work	ing	16b. Kind of Business	
V	led wi ygien her th	Co	12 17. Father's Name (First, Middle, Last)		Rea	l Estate	Broker 18. Mother's Name	n (First Middle A	Real Esta	ate .
Maryiand	ould be fi Mental H mrked ot atic ever	To Be	William Henry No				Georgie	Slingluf	f	
Mar	12 sh hand 7 is m treum		19a. Informant's Name/Relationship (T Leona Little Nor	• • • • • • • • • • • • • • • • • • • •					City or Town, State, wn, MD 21	
ָ בי	1 and Healt tem 2		20a. Method of Disposition		20b. Place of Dispo	osition (Name of			20c. Location - City or	
Ē	Pages ent of nt: If i		1 ☐ Burial 2 ☐ Cremation 3 ☐ 1 ☐ Donation 5 ☐ Other (Specify			matory`or other pla ke Cremat	1	. 2004	Stevensvil	11. MD
baltimore,	permit. Departm Importe any inju		21. Signature of Funeral Service Ligens	locus	Fe	2. Name and Addr	ess of Facility lelfenbein	& Newna		
oo,	Physician /Medical Examiner	cal Examiner	shock, or heart failure. List only of immediate Cause (Final disease or condition resulting in death) Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. CAN Due to (or as Due to (or as C.	a consequence of): a consequence of): a consequence of):	novary	ARREST			Interval Between Onset and Death
.O. BOX 00	To the Hospitel or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funerel Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal death 3	□Ectopic pregnand □ Other (specify)	су		23d. Date of de Month	olivery Day Year
v. T	v requires that the de been signed by the should be detached	þ	Part II. Other significant conditions of					8	pacco use contribute t	o the cause of death?
Hecords,	e law requir has been si je 2 should	Completed	History of Ca	//	astery D	/	eu Alzuri	24a. Was an autops	n 24b. Were a	utopsy findings available completion of cause of
O	n: Th	e Co	25. Was case referred to medical				26. Place of Deat			s 2 No
5	ysicia is cart direct	0 0	avaminar?	Hospital: 1 Inpatie	ent 2 ER/Outpatie	nt 3 DOA	ther		nce 6 □Other (Spe	ecify)
DIVISION OF VITAL	nding Ph th. r: After th e funeral	ation: T	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Inju (Month, Da	ry 28b. Time o y Year) Injury	W	ury at ork? □ Yes 2 □ No	28d. Describe ho	w infury occurred	
DIVIS	To the Hospitel or Attending Physician: The law within 24 hours after death. To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of In- building, et	ury - At home, farm, st c. <i>(Specify)</i>	treet, factory, office		28f. Location (St. City or Town	reet and Number or R , State)	ural Route Number,
	ne Hospit n 24 hour se Funere	Medical (of my knowledge, deal f examination and/or in ated.					
	To the within To the Comp	M	29b. Signature and title of certifier				se number	2	9d. Date signed (Mon	
			J. C. Clus	//1	. Mis.		3889		11/1/0	y
		C	30. Name and address of persen who		leath (Item 23a) (Type	, Print)	* (11. 1.	etmin. 7	11 1 2 11 .	
- #	Ç+	0 ate	JOHN (ATTRA13 A 31. Date filed (Month, Day, Year)		ar's Signature	A MAINE	1 (140)41	ronn, p	ud 2162	
4	Regist			004	- 18 1					

		1 - For State Registrar 1. Decedent's Name (First, Middle, Last)	State of Marylan		artment of F			No. 2 U U L	3663
Physici /Medio Examir	cal	Fmma Catherine 4a. Facility Name (If not institution, give s Ruxton Nursing	street and number) Home		Dento		Oct. 31,	4c. County of Death Caroli	10:15 p
Funeral Director		5. Social Security Number 6. Sex 220-05-7753	7. Age (In yrs.) 83	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month Day Y April 24	9. Birthi Govi 1921Mary	place (State or Foreigntry) Land
with the Maryland a or 28a-f show	Director	10a. State 10b. County Maryland Caroli 10e. Street and Number 25860 Dogwood Rd.		y, Town or Lo	ensboro 10f. Zip Code		10g	. Citizen of What Cour	Od. Inside City Limits 1 ☐ Yes 2 ☐ No.
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic avent. It was call Examinat must be notified at once.	by Funeral Director		12. Was Decedent Ever in U. Armed Forces? 1		Vas Decedent of H f Yes, specify Cuba	spanic Origin? (Spe n, Mexican, Puerto I	cify Yes or No- Rican, etc.)	USA 14. Race - Americ Black, White, Specify: Whi	etc.
within 72 h sne. Ihan "natu	Be Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	cation completed) College (1-4or 5+)	16a. Deced (Give life. L	lent's Usual Occupa kind of work done of OO NOT use retired	ation furing most of workin)	ng	b. Kind of Business/In	dustry
d 2 should be filed within 72 hours alt th and Mental Hygiene. 27 is marked other than "natural", or traumatic avent, "to West Call Exert	To Be Co	6 17. Father's Name <i>(First, Middl</i> e, Last) Samuel Joseph Su	ter		Homen	naker 18. Mother's Name Mary A			
and 2 should I ealth and Meni n 27 is marke		19a. Informant's Name/Relationship (Type Rosemary C. Vince	nt/Daughter	258	60 Dogwoo		Route Number, C	ity or Town, State, Zip	_
permit. Pages 1 ar Department of Hea Important: If item any injury or other once.		20a. Method of Disposition 1 □ Surial 2 □ Cremation 3 □ Ro 4 □ Donation 5 □ Other (Specify)	emoval from State	emetery, cren dlawn	sition (Name of natory or other plac Cemetery	11/5/	' 2004 B	altimore,	
permii Depar Impor any ir		21. S.m. ure of Funeral Service License	er fame	sel (3	urran-Bro 08 High S	s of Facility Name II Fur St., Cambr	eral Hom idge, MD	e, P.A. 21613	
Physician /Medical Examiner whisician and printing-transit the printing-transit	Examiner	Strock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	e cause of each line	Mer ience of):	_	nen ha	-		Approximate Interval Between Onset and Death
death certitic e attending p d tor use as	Physician/Medical E	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 \(\text{Yes} \) 2 \(\text{Yes} \) 0 9 \(\text{Unnown} \)	dc. If yes, outcome of pregnar 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of de 9 □ Unknown	ncy death 3 🗆	Ectopic pregnancy Other (specify)			23d. Date of delive Month	ry Day Year
es the	by	Part II. Other significant conditions conf	ributing to death but not resu	lting in the un	derlying cause give	n in Part I.	23e. Did tobacc	co use contribute to the	e cause of death?
The law ate has b page 2 sl	Completed						24a. Was an autopsy performed	prior to com	sy findings available ipletion of cause of 2 No
ding Phys	ation: To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Accident investigation	The second secon	ER/Outpatient 28b. Time of Injury	28c. Injury Work	at 28		6 Other (Specify,	
pita urs sral	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At hor building, etc. (Specify)				City or Town, St		
를 들 을 들	Medical	29a. Certifier (Check only one) 2 Medical Examination 29b. Signature arcuitle of certifier	cian: To the best of my knower: On the basis of examination and manner stated.	viedge, death on and/or invi	occurred at the time estigation, in my op 29c_License	nion, death occurred	d at the time, date :	and place, and due to	the cause(s)
To With		30. Name and address of person who con	le mo		D 3	5284	290.	Date signed (Month, D	ay, realj
-	111	20 Name and sides of	poloted sever of down to	00-1 -	-1				-

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 36632 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** etober 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BALTIMORE

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) AGNES eAlthCARE 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** INKNOWIN Yrs. Director Usual Residence of Decedent the Maryland 10b. County 10a State 10c. City, Town or Location 10d. Inside City Limits itam 27 is markad othar than "natural", or Itama 23a or 28a-f show othar traumatic evant, Ite Medical Examinar must be notified at MM Director WOOD 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21163 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, filed within 72 hours after Hygiene. Black, White, etc. 2 Married 1 Never Married Baltimore, Maryland 21215-0036 2 1 No Specify: ASIAN 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) is 1 and 2 should be filed within if Health and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) OH CHANG 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Nymber or Rural Route Number, City or Town, State, Zip Code) mother 2211 HUSTEN TMD MOODSTOCK 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition permit. Pages 1 Department of He Important: If itar any injury or oth 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State

'4 □ Donation 5 □ Other (Specify) BALTIMORE, NEW CATHEDRAL CEMETARY 2005 21. Signature of Funeral Service Licensee 22. Name and Address of Facility ST AGNES HEHLTH CARE De Advan Long pe 900 CATON AVE BALTIMORE, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final disease or condition resulting in death) Onset and Death Priysician eme /Medical to (or as a consequence of): **Examiner** Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine use as the burial-transit the attending physician and Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No 4☐Pregnant at time of death Month Day 5 Other (specify) P.O. 9 Unknown cetober 10, 2004 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 🗌 Yes 2 No 3 Probably 4 □Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Yes To the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) examiner Hospital: Inpatient 1 ☐ Yes 2 No Other: ပ 2 ER/Outpatient this 3□ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28c. Injury at Work? Certification: 28b. Time of After t Date o' jury (Month, Day Year) 28d. Describe how injury occurred Division 1 Natural 5 Pending death. 2 Accident investigation 1 Yes 2 No within 24 hours after deat To the Funaral Diractor: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Che only 29d. Date signed (Month, Day, Year) 0046308 pleted cause of death 42 23a) (Type, Print) e and address of person N AVE BAITO MD 900 trar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** NOV". 1, 2004 **EMILY** OTTI 10:55 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner SHADY GROVE ADVENTIST HOSPITAL ROCKVILLE MONTGOMERY | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 10.200 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Birthplace (State or Foreign Country) 1 □ M 2 🖔 F 647-03-3277 Director 73 12-12-1930 Nigeria Usual Residence of Decedent deeth with the Maryland 10a, State 10b. County 10c. City, Town or Location Item 27 is marked other than "natural", or Iteme 23a or 28a-f show other treumatic event. The Madical Examiner must be notified at 10d. Inside City Limits Maryland Director Montgomery Boyds 1 XYes 2 No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 20841 14104 Bear Creek Drive Nigeria 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Peges 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. Int: If Item 27 Is marked other than "natural", or Ite 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: þ Specify: Black 3 X Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Self-Employed 12th Nannie 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Edwin Achonye Rache1 Igbokwe 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14104 Bear Creek Drive 19a. Informant's Name/Relationship (Type, Print) Obiageli N. Uwazie/Daughter Boyds, Maryland, 20841 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State injury or 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State permit. Pege Department o Important: If any injury or once. *4 ☐ Donation 5 ☐ Other (Specify) Family Cemetery 11-17-04 Nigeria 22. Name and Address of FacilityW.H. Bacon Funeral Home, Inc. 21. Signature of Funeral/Service Licenses 3447 14th St., N.W. Wash., D.C. 20010 Wanda Jacon CC361 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Arry thmia Priysician minutes /Medical Due to (or as a consequence of): Examiner Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Usease or injury that initiated events resulting in death) Last Examine sicien and burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) attending physicien for use as the buria an/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1□Live birth 2 □ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day hysicia Month Year 4□ Pregnant at time of death 5 Other (specify) ned by the a 9 Unknow signed to be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 25 No 1 ☐ Yes 2 ☐ No 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 2 ER/Outpatient 3 □ DOA 28a. Date of Injury (Month, Day Year) in by the funeral 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred After Certification 5 Pending 1 Natural death. investigation 1 ☐ Yes 2 ☐ No 2 Accident after death 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 24 hours Decartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai (Check only one)

To the within 2

Division of Vital Records, P.O. Box 68760

Baltimore, Maryland 21215-0036

30 Name and address of person who completed cause of death (Item 23a) (Type, Print)

Across M Courdon M D 9901 Medical Center Dr., 31. Date filed (Month, Day, Year)

NOV 0 4 2004

auns M. Snyd

29b. Signature and title of certifier

Registrar's Signature

State

Registrar

MID

29c. License number

057129

29d. Date signed (Month, Day, Year)

Rockville, Md. 20850

2004

			1 - For Amend Items State Amend Items Registrar	s 23a,b,25	f Marylan , 27, 28	d / Depa	artment r. ME rtificate	t of H	lealth a Death	and M 8/05	ental Hygidhb	ene 0 ()4	366	34
	Discontact.		1. Decedent's Name (First, Middle								2. Date of Death Month		· · · · · · · · · · · · · · · · · · ·	3. Time of	_
	Physici /Medic		Flora Galt								October	Day 28 2	Year 2004	11:15	AΜ
	Examin	er	4a. Facility Name (If not institution Anne Arundel	. 0	,		4b. City,		Location			4c. County			
	Funeral		5. Social Security Number	6. Sex	7. Age (In yrs. i	last hirthday)	If Under		Anna]	olis				undel	
	Funeral Director		165–12–4919	1□ M 2∏F	84	Yrs.	Months	Days	Hours	Min.	8. Date of Birth (Month, Day, 1 March 15			olace (State ontry) otland	
	pu >		Usual Residence of Decedent 10a. State 10b. County		10- 0:5	-					I LOT 13	7 1324			
	Aaryla f shor	or		Arundel	roc. City	y, Town or Lo	cation	An	napo.	lis			1	10d. Inside Ci	
	28e-	Director	10e. Street and Number				10f. Zip				100	. Citizen of W	Vhat Cou		
	h with	al Di	7101 Bay Fron	t Drive,	#221				2140	03			S.A.		
	ams	Funeral	11. Marital Status	12. Was Dece Armed Fo	edent Ever in U.	S. 13.	Was Decede f Yes, spec	ent of Hi	spanic Ori	gin? (Spec	cify Yes or No-		e - Americ	can Indian,	
36	s afte	by Fu	1 Never Married 2 Marr 3 ₩ Widowed 4 Divorced	ied 1 ☐ Yes If Yes, Giv	2 1 ₹] No ′e		1 ☐ Yes 2		Specify:	.,	noun, oto.,	Specify		ite	
21215-0036	n 72 hours after death with the Maryland "netural", or Itams 23a or 28e-f show colleal Examiner must be notified at		15. Deceden	Year or Da	ates:	16a, Dece	dent's Usua	I Occupa	ition		16	b. Kind of Bu			
215	within 72 ene. than "ne	Completed	(Specify only highest Elementary/Secondary (0-12)	st grade completed) College (1	-4or 5+)	(Give	kind of won DO NOT use	k done d	lurina mos	t of workin	ig i	D. KING OF BU	311033/11	dustry	
	be filed within 72 ho ital Hygiene. ed othar than "netui avent, Ita Medical	Con		4		Adm	inist	rati				U.S. A			
Maryland	Ibe fill	Be	17. Father's Name (First, Middle, William Galt	Last)							(First, Middle, Ma awrie	iden Sumam	e)		
Ž	2 should be f and Mental I is marked of eumatic ave	2	19a. Informant's Name/Relations	hip (Type, Print)		19b. Mailin	n Address	(Street a			Route Number, (Situ or Town	State Zir	Code	
	ath a		Eric Pommer/so								der, Col		803		
Baltimore,	m 0 ,		20a. Method of Disposition	2 □Pamoval from t	20b. P	lace of Dispo emetery, cren						c. Location - (City or To	own, State	
ΪΪ	Pages Iment of I Iant: If its jury or o		'4 □Donation 5 □ Other (S	pecify)	June	yland '	Vets.	Cem	etery		/3/04 C				
Bal	permit. Page Department of Important: If any injury or once.		21. Signatur a uneral ervice	Licensee 7	(1)						n M. Tay				
		-	23a. Part1. Enter the disease, or	complications that ca	aused the death	Do not ente	/ Duke	e of dving	GLOU	cardiac or	er St.	Annapo	lis,	MD 21	_
	Pnysician		Immediate Cause (Final	only one cause on e	ach line.	. 1	No	1	,, 000,100	_	neumonia	•		Interval Bety Onset and D	veen
	/Medical		disease or condition resulting in death)	aDue to (w as a consequ	-	1)00	rate	200		.comonza		†	U 1000	75
П	Examiner		Sequentially list conditions,	b	NEU	ind	710	Hea	ıd In	jury			+	0 124 T	-
	led sit	nine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to	or as a consagu	ience of			Λ	0	WEO BY MEDICAL E	KAMINET			
<u>,</u>	execun and ial-tra	Examin	that initiated events resulting in death) Last	c. Due to (or as a consequ	ience of):			- V	N APPROV	VEO BY MEDICAL				
8760,	ficate be executed physician and sthe burial-transit	dical		d				C	ERTIFICATION						
9	ertifica ling ph e as t		IF FEMALE:	1					V			T			
Вох	death certific e attending p id for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months?		come of pregnar inth 2 □ Fetal ant at time of de	death 3	Ectopic pre					23d. Date Mon			ear
o.	0 0 0	nysic	1 Yes 2 No 9 Unknown	9□ Unkno		atri 5	Other (spe	спу)						,	
s, P	requires that the een signed by th hould be detache	by Pi	Part II. Other significant conditio	ns contributing to de	ath but not resu	lting in the un	derlying car	use give	n in Part I.		23e. Did tobac	co use contril	bute to th	e cause of de	ath?
ords	w require been sig should b										1 ☐ Yes	2508	3 🗌 Proba	ably 4 ⊡U	nknown
Record	aw is b	ompleted									24a. Was an autopsy	24b. W	ere autor	osy findings a	vallable
E H	Th ate pag	Con									performed	12 de	eath?	2130	
Vital	Physician: The this certificate ral director, pag	o Be	25. Was case referred to medical examiner?	Hospital:	γ			Othor	-		(Check only one)				
of	ding Phys h. After this funeral di	jan	1 X Yes 2 366 27. Manner of De th	28a. Date o	f Injury	R/Outpatient 28b. Time of		c. Injury	at Nur	-	e 5 🗌 Residenc 8d. Describe how)	
ion	Attanding or death. ector: After by the fune	atlo	2 Accident 5 ☐ Pending investig		7, Day Year) /2004	Injury Unkno	wrM	Work?	? es 2ĂN		Subject				
Division	I or Attan after deatl Director: I in by the	ertification;	3 ☐ Suicide 6 ☐ Could n 4 ☐ Homicide determi	ned 286. Place	of Injury - At hor	me, farm, stre	et, factory,	office		28	If. Location (Stree City or Town, S	t and Number	r or Rural	Route Numb	19 <i>1</i> ,
	pital o urs af aral D	0		Home							TOT bay	Front	DLIA	e,#221)
	To the Hospitel or Atten within 24 hours after deat To the Funeral Director: completely filled in by the	Medical	one) 2 Medicel	g Physician: To the Examiner: On the ba and mann	sis of examinati	vledge, death on and/or inv	estigation, i	n my opi	nion, deat	f place, an h occurred	at the time, date	and place, ar	nd due to	the cause(s)	
)	To Con	<	29b. Signature a/bt offle of centrer	Mark			29c.	License) \ \	84	29d.	O/2 E	(Month, E	Day, Year)	
				o completed cause	of death (Imm	23a) (Type, F	Print) AA	Une	Bloom	No	Sicioly (cake	1 :	2440	77
	Stat Registra		31. Date filed (Month, Day, Year) 0CT 2	9 2004 32.	gistrar's Signati	K A	and s))			- -	-

		-	For State Registrar	State of Marylan		rtment of H			iene 0	04	36635
	Physicia	an	1. Decedent's Name (First, Middle, Last) 1. Decedent's Name (First, Middle, Last)	JAMES	/	PROCTO	R	2. Date of Deat Month November	Day	2004	3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution, give s	treet and number)	lati	4b. City, Town, or	Location of Death	44		y of Death	ONE
	Funeral Director		379-32-3824		ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Sate of Birth Month, Day, 05/12/	Year) 1956	Cour	lace (State or Foreign http) ington, DC
	Marylend a-f show		Usual Residence of Decedent 10a. State Maryland Prince Ge		y, Town or Loc Indian					1	0d. Inside City Limits 1 ☐ Yes ※※No
	with the	Director	10e. Street and Number 4280 Livingston F	2 and		10f. Zip Code	20640	1	0g. Citizen of		ntry?
036	s 1 and 2 should be filed within 72 hours after death with the Marylend if Health and Mental Hygiene. Item 27 is marked other than "natural", or Items 23s or 28s-1 show item 27 is marked other than "natural", or Items 23s or 28s-1 show other traumatic event, Ite Madical Exteriors must be notified at	by Funeral		12. Was Decedent Ever in U. Armed Forces? 1 ☐ Yes 2 🖾 Mo If Yes, Give Year or Dates:		√as Decedent of H Yes, specify Cuba ☐ Yes 2 🖾 🛣	ispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Ra	USA ace - Americack, White,	
21215-0036	within 72 ho liene. r than "netur ine Medical	Completed	15. Decedent's Edui (Specify only highest grade Elementary/Secondary (0-12)		(Give I	ent's Usual Occup kind of work done DO NOT use retired Disable	during most of work d)	ing	16b. Kind of I	Business/In	dustry
land ;	ould be filed v Mental Hygie arked other l etic event, II	To Be C	17. Father's Name (First, Middle, Last) Elmer Eugene l	Proctor			18. Mother's Name	e <i>(First, Middle, I</i> ta E. Pre		ıme)	
Maryland	nd 2 should be Ith and Mental 27 is marked (27 traumetic ev		19a. Informant's Name/Relationship (Ty) Loretta E. Proctor				and Number or Rur on Rd. Inc				
Baltimore,			20a. Method of Disposition 1)∑NSMrial 2 ☐ Cremation 3 ☐ R '4 ☐ Donation 5 ☐ Other (Specify)	emoval from State Res	Place of Dispos emetery, crem Surrecti	sition (Name of patory or other place On Cem.			20c. Location Clinton		
Balti	permit. Page Department of Important: if any injury or		21. Signature of Funeral Service License		6	160 0 xon	ත්දේණ්රී Ka Hill Roa	d Oxon	Hill, M	nePA arylar	nd 20745
	Physician /Medical		23a. Part. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	5EPS/5		er the mode of dyir	ng, such as cardiac	or respiratory arr	est,		Approximate Interval Between Onset and Death
8760,	Examiner	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of the consequence of t	Uence of):	Liver 3	DisEA	SE			two years
P.O. Box 68	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Completed by Physician/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregnation 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of c	ıl death 3 ☐	Ectopic pregnancy Other (specify)	/			ate of deliving	ery Day Year
	quires that in signed b uld be deta	ed by Pl	Part II. Other significant conditions con	ntributing to death but not res	sulting in the ur	nderlying cause giv	ven in Part I.		bacco use co es 2□No		he cause of death?
of Vital Records,	The law requir ate has been si page 2 should	complet		-				24a. Was a autops perform	SV .	prior to co death?	opsy findings available impletion of cause of
Vita	Physicien: The I this certificate har ral director, page	Be	25. Was case referred to medical examiner?	Hospital:	IED/Outpation	. all post of	or	th (Check only or		thar (Space	5.1
on of	Attending Physic death. ector: After this by the funeral di	ation: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	1 ■ Inpatient 2 □ 28a. Date of Injury (Month, Day Year)	ER/Outpatien 28b. Time of Injury	28c. Inju	ry at	ome 5 ☐ Resid			у)
Division	el or Attendi s after death. Il Director: A sd in by the fu	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h building, etc. (Speci	ome, farm, str	eet, factory, office		28f. Location (S City or Tow		nber or Run	al Route Number,
	To the Hospitel or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	Medical (29a. Certifier (Check only one) 18 Certifying Phy 2 Medical Exami	sician: To the best of my kno ner: On the basis of examina and manner stated.	owledge, death ation and/or in	vestigation, in my	opinion, death occur	rred at the time, o	ate and place	a, and due t	o the cause(s)
)	To the within 2 To the complex	M	29b. Signature and title of certifier	RISTOV, 1	M.D.	29c. Licens	5 - 00		9d. Date sigr	ned (Month,	
K	2-(2)			U. WOLFE STRE	EET 1		E , MARY	LAND	2/28	7	
	St Regist	ate rar	31. Date filed (Month, Day, Year) NOV 0 4 2004	32 Registrar's Sign	ature	de la					

DHMH 17 Rev 1/2001

ORIGINAL

		-	For State Registrer	State of	f Marylan	d / Depa <i>Cer</i>	irtment of F tificate of	lealth a Death	and Mer		jieme leg. No.	004	366	37
			1. Decedent's Name (First, Middle,	Last)						Date of Dea Month	ith Day	Year	3. Time o	of Death
	Physicia /Medic		Margaret 1	Elizabeth	Pre	ssly				vembe		2004	6:30	P ^M
	Examin		4a. Fecility Name (If not institution,	give street and nun	nber)		4b. City, Town, o	r Location of	of Death		4c.	County of Dea	th	
			Wilson Health	Care Cent	er		Gaith	ersbui	cg		ı	lont gom	ery	
	Funeral		5. Social Security Number 6		7. Age (In yrs.	• • •	If Under 1 Year Months Days	If Under Hours	24 Hrs. 8. Min.	Date of Birth (Month, Day	Year)	9. Bir	thplace (State	or Foreign
	Director		517-22-4163	1 □ M 2 X F	79	Yrs.				t. 1,		5 Mo	ntána	
	pur 🛦	-	Usual Residence of Decedent 10a, State 10b, County		10c. Cit	y, Town or Lo	cation						10d. Inside (City Limits
	lanyik	ō	Maryland Montg	omery		aithers							1.0	s 2 No
	the N	ect	10e. Street and Number	Omery	0,	arther	10f. Zip Code				10a Citi:	zen of What C	ountry?	
	with a or	급	333 Russell Av	707110			208	77			-	ted Sta		
	eath	era	11. Marital Status		dent Ever in U.	.S. 13. \			igin? (Specify	Yes or No-		14. Race - Ami		
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or Itams 23a or 28a-f ahow amounts in your or other traumatic evant. The Machinal Exa. illing r. and be neithing at ance.	by Funeral Director	1 ☐ Never Married 2 ☐ Marrie 3 🛣 Widowed 4 ☐ Divorced	Armed For	rces? 2 📉 No re	1	Vas Decedent of I f Yes, specify Cub I □ Yes 2🗓 No			ın, etc.)		Black, Whi		
21215-0036	tura stura	ed	15. Decedent's			16a. Deced	ient's Usual Occup	oation			16b. Kir	nd of Business	/Industry	
15	n n	Completed	(Specify only highest Elementary/Secondary (0-12)	grade completed) Coilege (1	-40r 5+\	(Give	kind of work done DO NOT use retire	during mos d)	t of working					
212	yiene giene r tha	E	Cieffieritary/36condary (0°12)	1	-40r 5+)	Homem	aker				Ow	n Home		
þ	otha vant,	Bec	17. Father's Name (First, Middle, L.	ast)				18. Mothe	er's Name <i>(Fi</i>	rst, Middle,	Maiden	Sumame)		
ā	Ments Ments rked	10 5	William Blashf:			_		Ca	roline	Sidle	е			
Maryland	sho s ma		19a. Informant's Name/Relationshi	р (Турв, Print)Da	ughter	19b. Mailir	ig Address (Street	and Number	er or Rural Ro	oute Numbe	r, City or	Town, State,	Zip Code)	
Σ	and 2 saith 27 I er tre		Carolyn Pressly	Bazyluk/			Hillridg			Y-				95
Baltimore,	Fitan or oth		20a. Method of Disposition 1 □ Burial 2 X Cremation	3 Removal from 9	State 20b. F	Place of Dispo cometery, crem	sition (Name of natory or other pla	ce)	Nov.		20c. Lo	cation - City or	Town, State	
Ĕ	Page nent ant: I		`4 □Donation 5 □ Other (Sp.				tan Crem		2004			andria,	, Virgi	nia
alt	Departr Departr Importa any Inji	2.00	21. Signature of Funeral Service Li	censee	1.0	. /	. Name and Addre							
m	89 = 89		> Xuzlu		علاول	Xe 10	E. Deer	Park	Dr.	Gaith	ersb	urg, M	20877	
	Physician		23a. Part1. Enter the disease, or o shock, or heart failure. List o Immediate Cause (Final	nly one cause on e	aused the deat ach line. LZHE(0		ng, such as	cardiac or re	spiratory ar	rest,		Approxima Interval Be Onset and	etween
	/Medical		disease or condition resulting in death)	a	or as a conseq		2 1/2	CMZI					- (0	1
	Examiner	.	Sequentially list conditions	b										
	D #	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a conseq	uence of):								
	cate be executed physician and the burial-transit	саш	that initiated events resulting in death) Last	c. Due to	or as a conseq	wanaa af\:								
8760,	oe ex cian	Ē		Due 10 (or as a conseq	derice or).								
87	cate b	dicai	,	d								_		
9	death certificate be executed e attending physician and id for use as the burial-transi	/Me	IF FEMALE:	23c. If ves. out	come of pream	ancy	-					na n-1	15	
Вох	that the death certifined by the attending I	Physician/Me	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live b	irth 2 Feta	ıIdéath 3□	Ectopic pregnanc Other <i>(specify)</i>	у			2	3d. Date of de Month	Day	Year
	the de	ysic	1 ☐ Yes 2 🔀 No 9 ☐ Unknown	9□ Unkno		iealii 5	JOHNER (Specify) _							
P.0	that the ed by th detache	H.	Part II. Other significant condition	s contributing to de	eath but not res	ulting in the u	nderlying cause gr	ven in Part I		23e. Did to	bacco u	se contribute t	o the cause of	death?
ds,	requires een sign	d by								1 🗆 Y	es 2[□No 3□P	robably 4 🕱	Unknown
Ö	~ Q 70	Completed								24a. Was a	20	24h Were a	utopsy findings	available
3e	e la has	mp								autop	sv	prior to death?	completion of	cause of
a	ate pa										2 X No	1 🗆 Yes	2 X No	
Vital Records,		Be	25. Was case referred to medical examiner?	Hospital:			Ott		of Death (C					
of	Phys this ral di	. To	1 Yes 2 No	28a. Date	Inpatient 2 of Injury	28b. Time of				Describe h		Other (Spe	ecity)	
no	ding F h. After funer	tion	1 Natural 5 ☐ Pending	(Mont	th, Day Year)	Injury	Wo	ink?]Yes 2. □				200		
Division of	Attanding r death. actor; Afte by the fune	Certification:	3 Suicide 6 Could no	ot be and Diego	of Injury - At h	ome, farm, str	eet, lactory, office					d Number or R	ural Route Nui	mber,
Θ	after Dira	ertii	4 Homicide	buildi	ng, etc. '(Specil	(y)	, , ,			City or Tow	n, State))		
	To the Hospital or Attene within 24 hours after death To the Funarel Director; completely filled in by the	ai C		Physician: To the										
	a Hos 24 h a Fur	edicai		xeminer: On the ba										(s)
	To th within Fo th compl	Me	29b. Signature and title of certifier	118.			29c. Licen					signed (Mon		
			> III UUU	U Dlu	Lu.		D:	3156	3	1	JOV3	EMBER	2,20	YOX
	10		30. Name and address of person v	no completed caus	se of death (Iter	п 23а) (Туре.	Print)							
			CYAPLES N. 8 31. Date filed (Month, Day, Year)	ENNER	MD Segistrar's Signa	2018	NSSELL	HUEVA	NE, C	SAITH	ERSI	BURG, A	10 208	コン
	Sta Regist		NOV 03	2004	the said	19	Sporks							

		For Amend Item 1	• •	Department of Healt	h and Mental Hy		36638
		Registrar		Certificate of Dea	2. Date of D	Reg. No.	3. Time of Death
Physic	ian	Decedent's Name (First, Middle, Last)	Joe Cephas Phel	psphelos	Month ;	per 30, 200	11 0:12
/Medi Examii		4a. Facility Name (If not institution, give s		4b. City, Town, or Locati		4c. County of Dear	
_ Admi		709-Rosen		The state of the s	dge	Dorch	
Funeral Director		201-00-1000	M 2□ F 7. Age (In yrs. last t	Yrs. If Under 1 Year If Un Months Days Hou	der 24Hrs. 8. Date of Bi rs Min. 0C+, S	1929 No	thplace (State or Foreign bunty) rth Carolina
/land		Usual Residence of Decedent 10a. State 10b. County	10c. City, To	wn or Location	-		10d. Inside City Limits
a-t sh	ctor	MD Dorch	rester C	ambridge			1 1 No 2 No
with the	Director	10e. Street and Number	and Avan	10f. Zip Code	2	10g. Citizen of What Co	ountry?
ns 23s	Funeral	709 Rosen	12 Was Decedent Ever in U.S.	13. Was Decedent of Hispanic If Yes, specify Cuban, Mex	Origin? (Specify Yes or N		
ges 1 and 2 should be filed within 72 hours after death with the Maryland at of Health and Menial Hygiene. It item 27 is marked other than "natural", or items 23a or 28s-t show or other traumatic event, its Madical Executes required to other traumatic event, its Madical Executes required.	by Fun	1 Never Married 2 1 Married 3 Widowed 4 Divorced	Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	If Yes, specify Cuban, Mex		Specify: 0 1	a CK
72 hou	ted	15. Decedent's Educ (Specify only highest grade		a. Decedent's Usual Occupation (Give kind of work done during t	most of working	16b. Kind of Business	
within a	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	(Give kind of work done during to life. DO NOT use retired) Truck Driv		City Pu	blic Works
filed v Hygie other t		17. Father's Name (First, Middle, Last)			other's Name (First, Middle		preve
Mental Merked c	To Be	Cephas =	Jones		Eleanor	. Phelp	5
2 shoul and M ls mar!	-	19a. Informant's Name/Relationship (Ty)	1 1 - 100	9b. Mailing Address (Street and Nu	1 .1	ber, City or Town, State,	Zip Code) e. MD. 21613
1 and Health em 27		Vennett // 20a. Method of Disposition	helps 20b. Place	709- RUSE MU of Disposition (Name of	ont Ave, (20c. Location - City or	11.11
		1 Merital of Disposition 1 Merital 2 ☐ Cremation 3 ☐ R 1 ☐ Donation 5 ☐ Other (Specify)	ceme	rery, crematory or other place)	11-6-04	Cambria	to MAD
permit. Pag Department Important: any injury o		21. Signature of Funeral Service License	2/01/21/	22. Name and Address of Fi	1	ne P.A.	e MD 2/6/3
40260		23a. Pag1./Enter the disease, or compli	cations that caused the death.	5 10 WaSh o not enter the mode of dying, such	as cardiac or respiratory	arrest,	Approximate
Physician		shock or heart failure. List only or Immediate Cause (Final	cholmo	O Corcura			Interval Between Onset and Death
/Medical		disease or condition resulting in death)	Due to (or as a consequence				,0,,,,,
Examiner		Sequentially list conditions.	Due to (or as a consequence	0.00:			
ted nsit	Examiner	fi any, leading to immediate cause. Enter Underlying Cause (Disease or injury		o 01).			
te be executed ysician and ie burial-transit		that initiated events resulting in death) Last	Due to (or as a consequence	e of):			
physic the bi	dical		J				
death certificate e attending physi of for use as the I	√Me	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of pregnancy			23d. Date of de	livery
0 0 2	Physiclan/Medic	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1□Live birth 2 □Fetal dea 4□Pregnant at time of death 9□Unknown	tth 3 □ Ectopic pregnancy 5 □ Other (specify)		Month	Day Year
The law requires that the ate has been signed by th bage 2 should be detache	by Pł	Part II. Other significent conditions cor	ntributing to death but not resulting	g in the underlying cause given in P	Part I. 23e. Did	tobacco use contribute to	
v require been sig should b		End Stag	cking for	serse]Yes 2 546 3□P	robably 4 Unknown
e law r has be je 2 sh	Completed				24a. Wa	s an 24b. Were a prior to death?	utopsy findings available completion of cause of
					1 ☐ Yes	No 1 □ Yes	s 2 No
sician: certificarine	o Be	25. Was case referred to medical examiner?	lospital: 1 ☐ Inpatient 2 ☐ ER/	Other	Place of Death (Check only Nursing Home	rone) sidence 6 □Other (Spe	acify)
g Phys er this eral di	H-	27. Manner of Death	-	o. Time of linjury at linjury Work?		how injury occurred	,,
ttending is death. ctor: After / the funer	atlo	1 Platural 5 Pending investigation	(Moral, Bay Your)	M 1 ☐ Yes			
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director,	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, building, etc. (Specity)	farm, street, factory, office		(Street and Number or R own, State)	ural Route Number,
To the Hospital or Attentwithin 24 hours after death To the Funeral Director: completely filled in by the	edical C	29a. Certifier 1 Certifying Phy (Check only one)	sicien: To the best of my knowled ner: On the basis of examination and manner stated.	ige, death occurred at the time, dat and/or investigation, in my opinion,	te and place, and due to th death occurred at the time	e cause(s) and manner a e, date and place, and du	s stated. e to the cause(s)
To th To th compl	₩.	29b. Signature and title of certifier	An s	29c. License num	ber	29d. Date signed (Mon	th, Day, Year)
		> // fuffer	claw m	0260	388	NOU 2,	2004
		30. Name and address of person who co	empleted cause of death (Item 23	- // -	Hurlack	Ma 216	43
c	tate	31. Date filed (Month, Day, Year)	32. Regist r's Signature		1000	. 2016	
Regis		NOV 0 4	2004	14 Brailes			

State of Maryland / Department of Health and Mental Hygier 00 14

		•	For State Registrar	Otato	i wai y	(•	ficate of	Death	i Workai i iy	Reg. No.		30	009
			Decedent's Name (First, Mide	dle, Last)						2. Date of De				ne of Death
	Physicia /Medic		JULIA ANTOINE	TTE QUINN						Novem	_		004	2027
	Examin		4a. Facility Name (If not instituti	-				b. City, Town, or	r Location of De		4c.	County of De		
				Memori				VII. 1	Easto				albot	
	Funeral Director		5. Social Security Number 214–28–8060	6. Sex 1 ☐ M 2 💢 F	7. Age (In	yrs. last birth	,/ N	If Under 1 Year Months Days	If Under 24 H Hours Mi		v, Year)	9. 8 30 MA	Sirthplace (St Country) RYLAN	ate or Foreign
	and *	}	Usual Residence of Decedent 10a. State 10b. Coun	ty	10	c. City, Town	or Locat	tion					10d. Insid	de City Limits
	Maryland -f show fied at	ō				TIE COTED								Yes 2 No
	28a-	ect	MD QUEE 10e. Street and Number	N ANNE'S		HESTER		10f. Zip Code			10a. Citi	izen of What	Country?	
	with Ba or	٥	104 ADDISON C	опрт				21619			US		,	
	death with the ms 23a or 28a r must be noti	Funeral Director	11. Marital Status	12. Was Dec	edent Ever	in U.S.	13. Wa		lispanic Origin?	(Specify Yes or No erto Rican, etc.)		14. Race - Ar		ın,
215-0036	s i and 2 should be filed within 72 hours after death with the Marylan f Health and Mental Hygiene. It was 23s or 28s-1 show Item 27 is marked other than "natural", or items 23s or 28s-1 show other traumatic event, the Medical Examination as notified at	þ	1 ☐ Never Married 2 ☐ Ma 3 🙀 Widowed 4 ☐ Divorce	If You G	2 ∑ No ive			es, specify Cuba		erto Hican, etc.)		Black, W Specify:	white, etc.	
20	72 ho natur	sted	15. Decede	ent's Education lest grade completed,	1	16a. C	eceden	it's Usual Occup	ation during most of w	vorkina	16b. Ki	ind of Busine	ss/Industry	
21	12 should be filed within n and Mental Hygiene. 7 is marked other than "raumatic event, ILE Men	Completed	Elementary/Secondary (0-12)		1-4or 5+)			NOT use retired	during most of w	9				
2	lygier her th	Co	12	1		NU	RSE		10 Mathada M	lama /Final Bildella		DICAL		
and	be fi	Be	17. Father's Name (First, Middle HOLMES LEON L							ame (First, Middle) MARGARET		,		
3	d Mer narke	၉	19a. Informant's Name/Relation			19h I	Mailing /	Address (Street		Rural Route Numb			Zin Codal	
Maryland	nd 2 salth an 27 ls i		BRUCE LEON QU				_			GRASONV	-		21638	
	1 an Heal tem 2		20a. Method of Disposition		2	Ob. Place of D	Dispositi	on (Name of	1	Date		cation - City		te
Baltimore,	t. Page: tment o rtant: If ijury or		1 Mag Burial 2 ☐ Cremation 1 Donation 5 ☐ Other	(Specify)	State	WOODLAY PARK		EMORTAL	;11/	05/2004	EAST	CON, MI)	
Bal	Department Department		21. Signature of Funeral Service	e Licensee			FEL	LOWS, HI SHAMRO	ELFENBE	IN & NEWN CHESTER	AM F	UNERAL 2161	9 HOME,	P.A.
			23a. Part. Enter the disease.	or complications that st only one cause on	caused the each line.	death. Do no	t enter t	the mode of dyin	ng, such as card	iac or respiratory a	rrest,			l Between
4	Physician /Medical		Immediate Cause (Final disease or condition	Ven	wich	lar T	arh	neards	Ĩ.				7	and Death
			resulting in death)	Due to	(or as a co	nsequence of):	V					1 2 72	م الأيراد
	Examiner		Sequentially list conditions,	b. Se	254								6-10	SINS
	D ti	ine	Sequentially list conditions, Lany Lating to immediate cause. Enter Underlying Cause (Disease or injury	Due M	or as a co	nsa uence of	-	L = P.	1.				51	Adays
	ecute and I-tran	Examiner	that initiated events resulting in death) Last	c. Due to	(or as a co	nséquence of	ecy)	tinfec	run				Sever	a deigs
68760,	The law requires that the death certificate be executed to has been signed by the attending physician and bage 2 should be detached for use as the burial-transit				(0, 25 2 5		, .							
587	ortificate ing phys e as the	Medicai		d										
2.4	n certii anding use a		IF FEMALE: 23b. Was decedent pregnant	23c. If yes, ou								23d. Date of c	delivery	
Box	death ce a attendi d for use	Physician/	in the past 12 months? 1 ☐ Yes 2 No	4□Preg	nant at time	Fetal death of death		ctopic pregnancy ther <i>(specify)</i>	<u> </u>			Month	Day	Year
P.O.	that the de ned by the a	hys	9 Unknown	9□ Unki	nown									
	es tha igned be del	by P	Part II. Other significant condi	tions contributing to	death but no	ot resulting in t	he unde	erlying cause giv	en in Part I.	23e. Did t		ise contribute		
ord	w require been si should b	ed	Kenal tail	ure, on	dia	14505				- 1 '	Yes 2	□No 3□	Probably 4	Minknown
Division of Vital Records,	taw reas be	Completed	Coronary	Arteryo	liseas	e his	toru	7 of C	ABG	24a. Was		24b. Were	autopsy findi	ngs available of cause of
ď		Con	· ·	0		/		<i>,</i> ,		perfo	rmed? 2 No	death 1 🗆 Y	?	
ita	iclan: Th certificate rector, pag	Be (25. Was case referred to medic examiner?							eath (Check only o	one)			
<u></u>	Physicla this cerr al direct	2	1 ☐ Yes 25 No		Inpatient	2 ER/Outp		3□ DOA Oth	4 🗀 IAUISIIIA	Home 5 ☐ Resi			oecify)	
ū	fter fter iner	inol :	27. Manner of Death 1 Natural 5 Pend		of Injury oth, Day Ye	28b. Tir lnj		28c. Injun Wor		28d. Describe	how injur	y occurred		
Sic	tend Jeath tor: /	cat	3 Suicide 6 □ Coul		o of Injune	At home for			Yes 2 □ No	28f. Location (Stroot on	d Alumbar or	Pum I Pouto	Alumbar
ĬŽ	or At after of Direction by	Certification:	4 Homicide dete	mined 200. Flac	ling, etc. (S	Specify)	n, street	t, factory, office		City or To			nuiai noute	rvaniber,
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	ledical Ce	29a. Certifier 1/2 Certify (Check only 2 Medic	ring Physicien: To the	e best of m	y knowledge, amination and/	death or	ccurred at the tin	ne, date and pla	ce, and due to the	cause(s)	and manner	as stated.	se(s)
	To the H within 24 To the F complete	Medi	one)	and mai	ner stated.							<u> </u>		
	To vit.	e=	29b Signature and title of certif					29c. Licens				e signed (Mo		
			tolen	mn				DO	0000	60	011	vovem	iser, e	2004
j	OVIC		30. Name and address of person			- /		pital.	310 /	60 lashington	SI	Card-	MIN	
	Sta	te	31. Date filed (Months Pays it es	et, Easton	IV lyn Redstrar's		0100	10-1000	44 /	usningran	01,	CONTOY	1110	
	Registr		MOA .	3 2004	March	K	1	n. N						

066)		1 - State Amend Item 1&	State of Marylan Unpend Item 2	d/Depa 3a,27,	artment of 1 28a-f per	lealth an C me 68 Death	d Mantal by	Reg. No.	04	36640
	Divi-i		1. Decedent's Name (First, Middle, Last)					2. Date of D Month	eath Day	Year	3. Time of Death
رياد	Physici /Medic		ELMONTE STEPHA	N QUIGLEY				Novemb		2004	7:13 A M
	Examin		4a. Facility Name (If not institution, give s	treet and number)		4b. City, Town, o	r Location of D	Death	4c. 0	County of Death	
			Prince George's Ho			Cheverl				rince Ge	
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs.	last birthday) Yrs.	Months Days	If Under 24 Hours	Min. 8. Date of B	irth	9. Birth	place (State or Foreign Tand
	Director		212-71-7133		115.	2 9		08/23/	2004	Mary	- Idilu
	DU *		Usual Residence of Decedent 10a. State 10b. County	10c. Cit	ty, Town or Lo	ocation					10d. Inside City Limits
	sho sho	ō	MD D.C.C	90	eat Ple	agant					1 XYes 2 No
	28a-f	Director	MD P.G. C	0.	ac i ic	10f. Zip Code			10g Citiz	en of What Cou	ntry?
:	MILL BOY	ä	_				0742		-	J.S.A.	, .
	8 23	era	409 Eastern Aven	IUC 12. Was Decedent Ever in U	S 13		0743	? (Specify Yes or N		4. Race - Ameri	can Indian.
	Item Item	'n	11. Marital Status 1 ☑ Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☑ No		If Yes, specify Cuba	an, Mexican, P	? (Specify Yes or Nouerto Rican, etc.)		Black, White,	etc.
ဂ္ဂ	rs aff	by F	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2X No	Specify:		:	Specify: B.	lack
ş	be filed within 72 hours after death with the Maryland at Hygiene. So other than "naturel", or items 23e or 28e-f show event, the Madical Examinar must be multified at	Completed by Funeral	15. Decedent's Educ	cation	16a. Dece	dent's Usual Occup	ation		16b. Kin	d of Business/Ir	ndustry
င္	n 72	plet	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	(Give	kind of work done DO NOT use retired	during most of d)	working			
7.	iene. r than "	E o	Elementary/Secondary (0*12)	College (1-401 3+)							
Maryland 21215-0036	e filed within all Hygiene. I other than vent, the Mar	Bec	17. Father's Name (First, Middle, Last)				18. Mother's	Name (First, Middl		Sumame)	
<u>a</u>	Mental Mental arked o	To B	Bryan Quigley				Deid	cra Chase	е		
<u>ڇ</u>	GDEE	-	19a. Informant's Name/Relationship (Type	pe, Print)		-		or Rural Route Num			c Code)
Ž	nd 2 saith ar 27 is r treu		Bryan Quigley - Fa	ther	409	Eastern .	Avenue	; Seat Pl	easan	t, MD 2	20743
ଦ୍	f Health item 27 other tr	1 8	20a. Method of Disposition	20b. I	Place of Disponentery, cre	osition (Name of matory or other place	ce)	Date	20c. Loc	cation - City or T	own, State
Ę	Page ent o nt: #	1	1 ☐ Burial 2 ☐ Cremation 3 ☐ R 1 ☐ Donation 5 ☐ Other (Specify)	emoval from State Was	shingto	on Nat'i	Cem 1	1/05/2004	Sui	tland, N	MD
Baltimore,	permit. Pages 1 an Department of Heal Importent: if item 2 any Injury or other once.		21. Signature of Funeral Service License	96	2	2. Name and Addre	ss of Facility				
ä	Depa Impo any Ir		> Wendary	reenan		reeman F	unerai	Services	Maraz	1and 20	752
	Physician /Medical Examiner	er	23a. Part1. Enjer the disease, or compleshook, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a consec	plaine quence of):				arrest,		Approximate Interval Between Onset and Death
68760,	The law requires that the death certificate be executed the saben signed by the attending physician and orge 2 should be detached for use as the burral-transit	edical Examiner	Cause (Disease or injury	Due to (or as a consect.	quence of):						
O. Box (at the death certific by the attending pl tached for use as t	Physiclan/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	3c. If yes, outcome of pregn 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of o 9 □ Unknown	al death 3	⊒Ectopic pregnancy □ Other (specify)	У		2	3d. Date of deliv Month	ery Day Year
rds, P.	w requires that been signed b should be deta	by	Part II. Other significant conditions con	ntributing to death but not re	sulting in the I	underlying cause gru	ven in Part I.		tobacco us		the cause of death?
al Records,		Completed	Of Was seen referred to modified				OR Plant	per Yes	opsy formed? 2 \Begin{align*} No	24b. Were autroprior to condeath? Yes	opsy findings available ompletion of cause of
Vital		o Be	25. Was case referred to medical examiner? 1 ∑Yes 2 □ No	lospital: 1 ☐ Inpatient 2X	TER/Outson	nt 3□ DQA Ott		Death (C heck only ing Home 5□ Re		Mother (Sec.	ful
of	ding Phye h. After this funeral di	 	27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury Un (Month, Day Year)	,	of unk 28c. Inju	ry at rk? Yes 2 X No	28d. Describe	how injury	occurred un	c
Division	or Attendentifier deat	Certification:	2 Accident 3 Suicide 4 Homicide	28e. Place of Injury - At h building, etc. (Speci	nome, farm, si			28f. Location	(Street and own, State)	l Number or Rur	al Route Number. unk
	To the Hospitel within 24 hours a To the Funerel I completely filled	edical C		sician: To the best of my kn ner: On the basis of examin and manner stated.							
	To the H within 24 To the Fi complete	M	29b. Signature and title of certifier	^		29c. Licens				signed (Month,	
)			1 Corker	wD		O.C.N	1.E.		Novem	ber 3,	2004
1			30. Name and address of person who co	ompleted cause of death (Ite	т 23а) (Туре						
			O Para filed (14 arth O Variation	-(100)	oturo	111 Per	n Stre	et, Balti	more,	Maryla	nd 21201
	St Regist	ate	31. Date filed (Month, Day, Year) NOV 1 6 2004	2. Registrar's Sign		81					

DHMH 17 Rev 1/2001

ORIGINAL

			For State RegistrarAM	I3c∩C#CIÆ				id / Depa	artmeni rtificate			and M	ental Hy	/giene	004	,	36641
			HegistrarAvI Decedent's Nam	e (First, Middl	e, Last)	1/9/04,1	1,1//1,1/	3) 00.	imoure				2. Date of D				3. Time of Death
Physi			Marce	l Xav	ier	Rocca							Octobe	er 28	, 200°	ar 4	11:40 A.M
/Med Exam			4a. Facility Name (If not institution	n, give stree	t and numbe	r)		,		Location o	f Death			County of [
				ordan R					Beth			2411			ntgom		
Funera Directo			5. Social Security N	908	6. Sex 12© M		Age (In yrs. 75	last birthday) Yrs.	If Under Months	Days	If Under 2 Hours	Min.	8. Date of Bi (Month, D		Be	Birthp Coun 11e	lace (State or Foreign try) Ville, NJ
land W			Usual Residence o 10a. State	10b. County			10c. Ci	ty, Town or Lo	cation	-						1	0d. Inside City Limits
Many -f she		ğ	MD	Montgo	mery		Bet	hesda									12√DYes 2 DNo
with the 3a or 28s	i		10e. Street and Nu 5512 Jore		ıd				10f. Zip 208	Code 16				10g. Citi USA	zen of Wha	t Coun	itry?
Ite, INITED FIGURES 2.12.13.0000 s. 1 and 2 should be filed within 72 hours after death with the Maryland fleathth and Mental Hygiene. It health and Mental Hygiene. other traumstic event, the Medical Examiner must be notified at	ı	by Funeral Director	11. Marital Status		ried	Vas Deceder Irmed Force Yes 2 Yes, Give	s? ⊒ No		Was Deced		spanic Orig n, Mexican Specify:	gin? (Spe , Puerto I	cify Yes or N Rican, etc.)	0-	14. Race - A Black, V	Vhite,	etc.
72 hours "natural"		Completed b	3 ☐ Widowed	15. Deceder	it's Education			16a. Dece	dent's Usua kind of wor DO NOT us	l Occupa k done di	tion uring most	t of workin	ng	16b. Ki	nd of Busin	Whi ess/Ind	
withir ene. than		dmo	Elementary/Sec	ondary (0-12)	5+	College (1-4o	or 5+)	Presid		,		ss Se	rv.	Lan	011206	Se	rvices
filled Hygin other	•		17. Father's Name	(First, Middle,				FICELO	CIIC O	1 20			(First, Middle				LVICOS
should be nd Mental nmarked o	1	lo Be	Renaldo :	Rocca							Mary	y Lar	ıza				
i, Mal y Idliu Z 1 Z 1 and 2 and 2 should be filed within eath and Mental Hygiene. In 27 la marked other than her traumatic event, I an Mental Mental and I	ľ		19a. Informant's N Lawrence			Print)			•				Route Numb			te, <i>Zip</i> 025	
ages 1 and 2 not of Health at 11 if item 27 I	6		20a. Method of Dis	Cremation	3 Remo	val from Sta		Place of Disponding COMIO	patery eco	BAS PLACE	Bry N		4,2004 2004		cation - City andri		
parmit. Pages 1 a Department of Hei Important: if item any injury or othe	once.		21. Signature of F		-/-			2:	2. Name an	d Addres		yJose	ph Gav	vler'		s I	
			23a. Part1. Enter shock, or hea	the disease, or	r complication only one care	ons that caus	sed the dear			-					din objection		Approximate Interval Between
Physicia /Medica			Immediate Cause disease or conditi- resulting in death)	on	a	Non -		cins Ly	mphom	a	_					s	ince 1992
Examine		_	Sequentially list co	onditions,	b	Due to (or a											
ocuted nd transit	1	Examiner	Sequentially list or if any, leading to in cause. Enter Und Cause Usease of that initiated event	S	6			,									
OX CO/OU, certificate be executed rding physician and use as the burial-transit		ical Ex	resulting in death)	Last	d	Due to (or a	as a consec	quence of):									
OX OO OX OO OX OO OX OO OX O		iclan/Med	IF FEMALE:		23c.	f yes, outcon	ne of pregn	ancy							23d. Date of	delive	IN.
U. DO. the death of the attern ched for u		Physiciar	23b. Was deceder in the past 12 1 Yes 2 9 Unknown	2 months?		1 □Live birth 4 □ Pregnant 9 □ Unknown	at time of o		Ectopic production of the control of				Section 60		Month		Day Year
GOLGS, P.O. BOX OR wrequires that the death certifica been signed by the attending ph should be detached for use as it		by	Part II. Other sign	ificant conditi	ons contrib	uting to death	but not res	sulting in the u	nderlying c	ause give	n in Part I.				se contribu		e cause of death?
ne The lar te has age 2		Completed													24b. Wer prior deat 1 🗆	to con h?	psy findings available inpletion of cause of
VICAL ician: certifica rector, p		BeC	25. Was case refe	rred to medica	ıl						26. Place	of Death	(Check only				
Of VICE Physician: rthis certific ral director,		0	examiner? 1 ☐ Yes 2 🖸		Hosp	1 📙 Inpa		ER/Outpatie			4 🗌 190	rsing Hor	ne 5🏋 Res	idence (6 □Other (Specify	<i>'</i>)
ding After			27. Manner of Dea 1 ★ Natural 2 Accident	5 Pendi	ng igation	8a. Date of Ir (Month, I	njury Day Year)	28b. Time o Injury	f 2	8c. Injury Work 1 🔲 Y	at ? ′es 2⊡t		8d. Describe	how injur	y occurred		
in the second		Certification:	3 🗌 Suicide 4 🔲 Homicide	6 ☐ Could determ		8e. Place of building,	Injury - At h etc. (Speci	ome, farm, st	reet, factory	, office		2		(Street an own, State		r Rura	l Route Number,
To the Hospital or Attent within 24 hours after deatl To the Funeral Director: completely filled in by the		edical	29a. Certifier (Check only one)				of examina	owledge, deat ation and/or in									
To the within 2 To the comple	â	Me	29b. Signature and	d title of certifie		uso	Y07			License	349	917	7	11	e signed (M	Jopin, L	Day, Year)
80	ים		30. Name and add	tress of person	who comp	eted cause of	of death (Ite	m 23a) (Type.	Print)	INA	SHINE	102	DC	200	27		_ /
Regi	Stat istra		31. Date filed (Mo.		2004		strar's Sign			relsi							

			For State	State of Marylar				Mental Hyg	iene 2004	36642
			State Registrar 1. Decedent's Name (First, Middle, Last)		Cer	tificate of l	Jeath	2. Date of Dea	ogi ito:	3. Time of Death
	Physicia	an	John William	Rayne				Month	Day Year	
	/Medic Examin		4a. Facility Name (If not institution, give s		-	4b. City, Town, or	Location of Death		4c. County of De	
	Examin	eı	PENINSULA REGIONA		Carro		Alubum		1/	onico
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs.	. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth	Year) 9. B	rthplace (State or Foreign Country)
4	Director		218-34-3270	67	Yrs.			March 12	2, 1937 _M	aryland
	land		Usual Residence of Decedent 10a. State 10b. County	10c. Ci	ity, Town or Lo	cation				10d. Inside City Limits
	Mary -1 sho	ţō	Maryland Wicomic	Co.	lisbury					1 XYes 2 ☐ No
	h the	Director	Maryland Wicomic	O Da.	TISDULĀ	10f. Zip Code		1	0g. Citizen of What 0	Country?
	th wit	al D	421 Jefferson Stre	et		2180	04		USA	
	r dea	Funeral		12. Was Decedent Ever in U Amed Forces?	J.S. 13. V	Vas Decedent of H	ispanic Origin? (Sp in, Mexican, Puerto	pecify Yes or No- o Rican, etc.)	14. Race - Am Black, Wh	
9	hours after death with the Maryland tural', or ttems 23a or 28a-f show al Exicoline Foust be nettified at	by Fi	1 X Never Married 2 Married 3 Widowed 4 Divorced	1 X Yes 2 No If Yes, Give	. 1	☐ Yes 2X No	Specify:		Specify:	1.
2-0036	72 hours "natural",		15. Decedent's Edu	Year or Dates: Arm		ent's Usual Occupa	ation		16b. Kind of Busines	White s/industry
5	f within 72 ho jene. r than "natur if e M. vic.i.	plet	(Specify only highest grade Elementary/Secondary (0-12)		(Give	kind of work done of OO NOT use retired	during most of world	king		
77.		Completed	12	College (19401 34)	None					
g	be filed stal Hygis of other event, I	Be (17. Father's Name (First, Middle, Last)				18. Mother's Nam	ne (First, Middle, I	Maiden Sumame)	
<u> </u>		၉	Edgar	Rayne			Virgini			Smullen
Maryland	C1 00 00 00		19a. Informant's Name/Relationship (Ty						, City or Town, State,	
	1 and Health em 27 ther tr		Barbara Lee Pirie 20a. Method of Disposition	(sister)	820 So		maker, S		, Maryland	
altimore,	Pages nent of l ont: If it		1 ☐ Burial 2 【☐ Cremation 3 ☐ R 3 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	cemetery, crem	natory or other plac	1		_ ′	
┋			21. Signature of Funeral Service License							, Maryland
ñ	permit. Departr Importa		Mr. A Haller	h APS					essional . oury, Mary	Association land 21804
			23a. Part1. Enter the disease, or complishock, or heart failure. List only or	oations that caused the dea	th. Do not ente	er the mode of dyin	g, such as cardiac	or respiratory arr	est,	Approximate Interval Between
	Physician			Onset and Death						
	/Medical		disease or condition resulting in death)	Due to (or as a consec			0,4,7			
	Examiner		Sequentially list ounditions,	HTN						
	ed sit	lner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consec	quence of):					
	and al-tran	Examin	that initiated events resulting in death) Last	Due to (or as a consec	quence of);					(341)
8760	cate be executed physician and the burial-transit	dlcal E								
89	8 E E	edic								
Box	at the death certific by the attending p stached for use as	Physician/Me	23b. was decedent pregnant	3c. If yes, outcome of pregn 1 □ Live birth 2 □ Feti	ancy	Ectopic pregnancy			23d. Date of de	
	deat	sicia	in the past 12 months? 1 □ Yes 2 □ No	4 Pregnant at time of a		Other (specify)			Month	Day Year
o.	The law requires that the tite has been signed by the bage 2 should be detache	Phy	9 Unknown			- 1967		OZE Didas		to the course of death 0
S,	ires thai signed b	ρ	Part II. Other significant conditions cor	tributing to death but not res	suiting in the ur	iderlying cause give	en in Part I.			to the cause of death?
Ö	w require been signature	eted								
Records,	sicien: The law certificate has l irector, page 2 s	Completed						24a. Was a autops perforr	v prior to	utopsy findings available completion of cause of
<u></u>	(0 11		25. Was case referred to medical				00 Bloom / Book	1 ☐ Yes 2	2 ☐ No 1 ☐ Ye	s 2□No
Vital	ysicie is certi directo	o Be	examiner?	ospital: 1 Inpatient 2	ER/Outpatien	3 DOA Othe		th <i>(Check only on</i>	e) ence 6 □Other (Sp	ocifu)
o	g Phy er this eral c	H-1	27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of	28c. Injury Work	/ at		w injury occurred	scriy)
Division	ath. r: After ne funer	Certification:	1 ☐Natural 5 ☐ Pending 2 ☐ Accident investigation	(INGITET, Day 16at)	Injury		Yes 2 □ No			
<u> </u>	or Attendate death Director: ,	tific	3 Suicide 6 Could not be determined	28e. Place of Injury - At h building, etc. (Speci	nome, farm, stre	et, factory, office		28f. Location (St City or Town	reet and Number or F n, State)	Rural Route Number,
	ital o irs aft ral Di lled in									
	To the Hospital or Attending Physicien: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	edical	(Check only 2 Medical Examin	sician: To the best of my kn	owledge, death ation and/or inv	occurred at the time estigation, in my or	ne, date and place, pinion, death occur	, and due to the ca rred at the time, d	tuse(s) and manner a ato and place, and du	s stated. e to the cause(s)
	o the ithin 2 o the omple	Med	29b. Signature and title of certifier	and manner stated.		29c. License	number	2	9d. Date signed (Mgr	th. Day, Year)
	⊢≯⊢ŏ		1 (do Jume	ma)		04	1827			004
(h	A		30. Name and address of person who co	mpleted cause of death (Ite	m 23a) (Type, I	Print)	/		1	/
V	DQ			KAMAN, M.	0. /	D4 poo E. Ch Sporks	IKRUII	51.	ALISHUM	mo
	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Sign	ature 4	1	/			
	Registr	ar	NOV 0 3 200	4 Jeneral		sparks				

| 100. Street and Number 100. 2p Codes 100. Critical of What Country? 100. Street and Number 100. 2p Codes 100. Critical of What Country? 100. Street and Number 643 |
|--|-------------------------|
| Funded Directors Social Security Number S. Social Sec | |
| Usual Residence of Decedering 100. Colory 100. City, Town or Location 100. Marked 100. Country 100. City, Town or Location 100. City Town or Locati | or Foreign |
| Ruby L. Padgett - Sister 2008 Amber Heat Place, Apt. 12, Waldorf, MD 206 20a. Mathod of Disposition 1 | City Limits
s 2 ☐ No |
| Physician Medical Examiner Physician Medical Examiner Penalta Cause (Final disease or condition resulting in death) Penalta Cause (Final disease or condition resulting in death) Penalta Cause (Final disease or condition resulting in death) Penalta Cause (Final disease or condition resulting in death) Penalta Cause (Final disease or condition resulting in death) Penalta Cause (Final disease or condition resulting in death) Penalta Cause (Final disease or condition resulting in death) Penalta Cause (Final disease or condition resulting in death) Penalta Cause (Final disease or condition resulting in death) Penalta Cause (Final disease or condition resulting in death) Penalta Cause (Final disease or condition resulting in death) Penalta Cause (Final disease or condition resulting in death) Penalta Cause (Final disease or condition resulting in death) Penalta Cause (Final disease or condition resulting in death) Penalta Cause (Final disease or condition resulting in death) Penalta Cause (Final disease or condition and consequence of): Due to (or as a consequence o | and. |
| Second S | etween |
| Description of completion of cheath? Page 1 No 3 Probably 4 Research Year |
24a. Was an autopsy findings prior to completion of c death?	death? Unknown
26. Place of Death (Check only one) aximiner? 1 Yes 2 No	available cause of
1 Matural 5 Pending investigation 2 Accident investigation 3 Suicide 6 Could not be determined 5 Suicide 6 Could not be determined 5 Suicide 6 Sui	nber,
29a. Certifier 29a. Certifier Check only Che	s)
29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 11 - 62 - 200	
30. Name and a ress of person who completed cause of death (Item 23a) (Type, Print) Mohsin Ijaz, M.D. 11119 Rockville Pike, #100, Rockville, MD 20852 State Registrar NOV 0.5 2004	

	1 - For State Registrar	State of Ma	aryland / Depa	artment of rtificate of		-	giene Reg. No.2 0	04	36644	
Physician	Decedent's Name (First, Middle, Last)					2. Date of De	Day	Year	3. Time of Death	
/Medical Examiner	Helen R. 4a. Facility Name (If not institution, give	4b. City, Town, or Location of Death			30, 2004 8:44 p M					
Examiner	Suburban Hospita	Bethesda			Montgomery					
Funeral	5. Social Security Number 6. So	If Under 1 Year If Under 24 Hrs. 8. Date of Bi Months Days Hours Min. July 2			rth ay, Year) 9. Birthplace (State or Foreign Country)					
Director	Usual Residence of Decedent	□M 2□F	90 Yrs.			July 23	, 1914	Mass	áchusetts	
yland	10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits									
8a-f s	Maryland Montgomery Potomac						1 X Yes 2 □ No			
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural", or Itams 23a or 28a-f show minjoury or other treumatic event, the Medical Examinant by notified at once. To Be Completed by Funeral Director	10e. Street and Number 10301 Iron Gate R	Road		10f. Zip Code 20854			10g. Citizen of What Country? U. S. A.		try?	
5 uter death with the Ma in terms 23a or 28a-f s direr must be notified funeral Directol	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent I Armed Forces? 1 ☐ Yes 2 🔼	No.		Hispanic Origin? (S ban, Mexican, Puert	pecify Yes or No o Rican, etc.)		e - America k, White, e	etc.	
Baltimore, Maryland 21215-0036 semit. Pages 1 and 2 should be filed within 72 hours all appartment of Health and Mental Hygiene. mportent: if item 27 is marked other than "natural; or nny injury or other treumatic event, the Medical Exerci- ance. To Be Completed by F	3 ☑ Widowed 4 □ Divorced If Yes, Give Year or Dates: 15. Decedent's Education I6a. Decedent's Usual Occupation						Specify: White			
21215-00 ed within 72 hot vgjene. Per then "natura to the medical to the medical Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) (Give kind of work done during most of working life. DO NOT use retired)					king	Own Home			
221 Siled with the tite of the	12 Years 17. Father's Name (First, Middle, Last)			Homemak	er 18. Mother's Nam	ne (First Middle				
yland vuid be fi Mental H arkad otl stic ever	Isaac Carlin Elizabeth Glick							·		
Tary 2 short and he is made euma		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)								
e, N 1 and Health em 27 ther ti	Leslie R. Cohen -	- Daughter			ate Road,		, Maryl 20c. Location -		20854 wn. State	
More and a segment of the segment of	1 M Burial 2 T Cremation 3 A Reproval from State Crawford St. Synacogule						Boston, Massachusetts			
Saltin ermit. F epartm mporter ny injur	21. Signature of Fundal Service Licensee 22. Name and Address of Facility Danzansky-Goldberg Memorial Chapels. Inc.									
W 40.5 e d	1170 ROCKVIIIe PIKE, ROCKVIIIE, MD 20032									
Pnysician	snock, or heart failule. List only Immediate Cause (Final disease or condition	shock, or heart failute. List only one cause on each line. Interval Between Onset and Death								
/Medical Examiner	resulting in death) Due to (or as a consequence of):									
	Sequentially list conditions, if any, leading to immediate cause. Little Underlying Cause (Disease or injury	b. PNEUMONIA Due to (or as a consequence of):								
amin amin	that initiated events	PARKINSON'S DISEASE								
ordificate be executed ording physicien and use as the burial-transit	resulting in death) Last	Due to (or as a consequence of):								
687 687 687 687 687 698 698 698 698 698 698 698 698 698 698		. d								
P.O. Bc that the death ed by the atter detached for or	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown					23d. Date of delivery Month Day Year			
	Part II. Other significant conditions c	ontributing to death b	aderlying cause given in Part I.		23e. Did tobacco use contribute to the ca		e cause of death?			
ecords, law requires th as been signe 2 should be or pleted by						1 🗆 1	1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 📆 Unknown			
The lay age 2 page 2						24a. Was autop perfor 1 Yes	rmed?	Vere autoportor to com leath?	sy findings available apletion of cause of	
/ita	25. Was case referred to medical examiner? 1. Ves 2. W.No. Hospital: 1. W. Inspiration 1. Classification 2. Classification 3. Classificat									
- 2 sig 5	27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred									
Vision Vision Attending or death. ector: Atte by the tune	1 XNatural 5 □ Pending (Month, Day Year) Injury Work? 2 □ Accident investigation M 1 □ Yes 2 □ No									
DIA Hospital or Hospital or Hours afte Funeral Dir ally filled in ical Cert	3 Suicide 6 Could not be determined	286. Place of Inju	Injury - At home, farm, street, factory, office etc. (Specify)				3f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
To the within 2 To the omplet	29b. Signature and title of certifier	. /	ก	29c. Licen	se number		29d. Date signed	(Month, D	Pay, Year)	
	Norma		1,0801		47330		OCTOBER	31,	2004	
	30. Name and address of person who THOMAS V. JOSEPH				, #207 R	OCKVILLE	, MD 2	0852		

		-	For State Registrar	State of M	aryland / Depa <i>Ce</i>	artment of H	lealth and Death	d Mental Hyg R	giene 004	36645
			Decedent's Name (First, Middle, Last)					2. Date of Dea	th	3. Time of Death
	Physicia		Helen S. Redding					Month October	Day Yea 24. 2004	4.25 PM
	/Medic Examin		4a. Facility Name (If not institution, give s	treet and number)		4b. City, Town, o	r Location of De		4c. County of D	
	ZAGIIIII		Suburban Hospital			Bethesd	a, MD		Montgom	erv
	Funeral		5. Social Security Number 6. Sex		ge (In yrs. last birthday)	If Under 1 Year Months Days		Hrs. 8. Date of Birth (Month, Day	9. 8	Birthplace (State or Foreign Country)
	Director		206.03.7936	M 240 F	86 Yrs.	Nonais Bays	110010	Mar.12,		oungwood, PA
	pur *	}	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Le	ocation				10d. Inside City Limits
	sho	ō								1 Tyes 2 □ No
	28a-f	Director	D.C. None		Washingto	10f. Zip Code			l0g. Citizen of What	<u> </u>
	with t		4214 Brandywine St	N 1.7		20016			USA	Country?
	s 23	Funeral		12. Was Decedent	Ever in IIS 12		licannia Origin?	(Specify Yes or No-		merican Indian,
	ltam Itam	nu	11. Marital Status 1 Never Married 2 Married	Armed Forces	?	If Yes, specify Cuba	an, Mexican, Pu	uerto Rican, etc.)	Black, W	
36	I', or	by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 🗓 No	Specify:		Specify: W	nite
ò	within 72 hours after death with the Maryland ene. Than "natural", or Itams 23a or 28a-f show he Madical Excinition is ust be inclifted at	ed	15. Decedent's Edu		16a. Dece	dent's Usual Occup	ation		16b. Kind of Busine	ss/Industry
15	n n	Completed	(Specify only highest grade	College (1-4or	life.	kind of work done DO NOT use retired	during most of d)	working		
212	d with	E	Lienteritary/3econdary (0-12)			retary			Clerical	
ğ	e filed Il Hygid Other	Be C	17. Father's Name (First, Middle, Last)				18. Mother's I	Name (First, Middle,	Maiden Surname)	
lar	should be and Mental s marked o	TO E	James G. Smitel	nurst			Kather	ine Becke	r	
Maryland 21215-0036	L P		19a. Informant's Name/Relationship (Typennis Redding/Sor					N.W., Was:		
Baltimore,	permit. Pages 1 and 2 Department of Health Important: If item 27 any injury or other tra	İ	20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ R	emoval from State	20b. Place of Disponentery, cre Mt. Comfo	matory or other plac	10/	Date /27/2004	20c. Location - City Alexandri	
3altin	permit. P. Departme Important any injury once.		4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service License	90	2	2. Name and Addre		oseph Gawl	Ler's Sons	Inc.
	40 = 4 G		23a. Part1. Enter the disease, or compli					e. N.W., V		Approximate
			shock, or heart failure. List only or	ne cause on each I	ine.	ter the mode of dyir	ig, such as care	diac of respiratory arr	651,	Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)	Hypot	ension					1 day
	/Medical Examiner		resulting in dealin)		a consequence of):					
Н		<u>.</u>	Sequentially list conditions,	Sepsi	S a consequence of):		-			
	ed Isit	ine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Discass of Jun) that initiated events	D00 to (01 as	a consequence or,					
	be executed sician and burial-transit	Examiner	that initiated events resulting in death) Last	Due to (or as	a consequence of):					
8760,	be e ician buria	alE								
387	physics the l	dical		J						
9 X	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Me	IF FEMALE:	3c. If yes, outcome	of pregnancy				23d. Date of	delivery
Вох	atter for u	clar	23b. Was decedent pregnant in the past 12 months?	1 Live birth 4 Pregnant a		☐Ectopic pregnancy ☐ Other (specify)	1		Month	Day Year
O.	that the de ed by the detached	iysi	1 ☐ Yes 2 🔀 No 9 ☐ Unknown	9☐ Unknown		_ + (-,)/				
Δ.	res that the igned by be detact		Part II. Other significant conditions con	ntributing to death t	but not resulting in the u	inderlying cause giv	en in Part I.	23e. Did to	bacco use contribute	to the cause of death?
ds	uires sigrald be	d by						1 🗆 Y	es 2□No 3□	Probably 4 ⊠Unknown
Records,	w require been sly should t	Completed						24a. Was a	n 24b Were	autopsy findings available
Rec	has ge 2	шр						autops perfor	sy prior t med? death	o completion of cause of ?
a	sician: The law certificate has b irector, page 2 s		or War and the medical						X	es 2 No
of Vital	Physician: this certific ral director,	9 Be	25. Was case referred to medical examiner? 1 Tyes 2 No	lospital: X Inpati	ent 2 ER/Outpatie	ot all DOA Oth	OC.	Death (Check only or		
of	Phy rald	1: To	27. Manner of Death	28a. Date of Inju	ury 28b. Time o	IL SEL DOA	4 🗀 14012111		ow injury occurred	о <i>вспу)</i>
Division	ding h. Afte fune	tion	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Da	ay Year) Injury		k? Yes 2 ☐ No			
S	dea ctor	flca	3 ☐ Suicide 6 ☐ Could not be	28e. Place of In	ijury - At home, farm, st	reet, factory, office				Rural Route Number,
Div	after Dira Jin b	Certification:	4 Homicide	building, e	tc. (Specify)			City or Tow	n, State)	
	To tha Hospital or Attanding within 24 hours after death. To tha Funaral Diractor: Afte completely filled in by the fune		29a. Certifier 12 Certifying Phy	sician: To the best	t of my knowledge, dea	th occurred at the tir	me, date and pl	ace, and due to the c	ause(s) and manner	as stated.
	a Ho 24 F a Fui letely	Medical	(Check only 2 Medical Exami one)	ner: On the basis of and manner s	of examination and/or in	vestigation, in my o	pínion, death o	ccurred at the time, d	ate and place, and o	ue to the cause(s)
	To th withir To th	Me	29b. Signature and title of certifier	0		29c. Licens	e number		9d. Date signed (Mo	
	10		· drum	-		D37891			October 24	
~	10		30. Name and address of person who co	ompleted cause of	death (Item 23a) (Type	Print)		1 1 Hdu	00 11	417
			Arajvans		D 131	Congress	Sium a	1 Cn, The	Kockvill-	e, NID 20852
	Sta	ate	31. Date filed (Month, Day, Year)		rar's Signature	Ann. 11	11			e, MD 20852
	Regist	rar	NOV 0 3 201	14 Pen	wa B	popula				

			For State Registrar	ate of Ma				of H	ealth a		ental Hyg	jiene	. 1	20010
	Division		Decedent's Name (First, Middle, Last)	_							2. Date of Dea	th	C O O H	3 Tilo dobeath O
	Physicia /Medic		Florence Virgini								Oct 2	_		5:25 A M
	Examin	er	4a. Facility Name (If not institution, give street		+ o 1		4b. City, Cli		Location o	f Death		4c.	County of Deat	m George's
			Southern Maryland 5. Social Security Number 6. Sex			last birthday)	If Under		If Under 2	24 Hrs.	8. Date of Birth	1		thplace (State or Foreign
	Funeral Director		578 07 5664 1 M 2		84	Yrs.	Months	Days	Hours	Min.	8. Date of Birth (Month, Day Sept 2	6, Year)	1919 Mar	ryland
	ryland how		10a. State 10b. County		10c. Cit	y, Town or Lo	cation							10d. Inside City Limits
	Ba-fs	Director	Maryland Prince Georg	e's		Suit1a								1 □ Yes 2□ No
	filed within 72 hours after death with the Maryland Hygiene. Ither than 'natural', or Itams 23e or 28e-f show int, the Medical Examination notified at		10e. Street and Number 4714 Hudson Ave A	pt C			10f. Zip	207	46				izen of What Co ited Sta	
	ar dea tams	Funeral	A	as Decedent med Forces?		.S. 13. V	Vas Deced Yes, spec	ent of His	spanic Orig	gin? (Spe i, Puerto F	cify Yes or No- Rican, etc.)		14. Race - Ame Black, Whit	
36	irs afte	by F	1 ☐ Never Married 2 ☐ Married 1 If 3 ☐ Widowed 4 ☑ Divorced Y	JYes 2√√√ Yes, Give XX ear or Dates:	No	1	☐ Yes 2	XX	Specify:				Specify:	White
ŏ	2 hou		15. Decedent's Education (Specify only highest grade corr	n(atad)		16a. Deced	lent's Usua kind of wor	l Occupa	ition	t of workin	20	16b. Ki	ind of Business/	
21	within in the series of the se	Completed		ollege (1-4or	5+)	life. L	OO NOT us	e retired))	or working				
72	filed withii Hygiene othar than rant, the w		17. Father's Name (First, Middle, Last)			Kecc	ord Ke			r's Name	(First, Middle,			eographic
Maryland 21215-0036	a d d d d d d d d	To Be	Harry I. Ward	er							B. Bowe		Camamo	
ary	s 1 and 2 should f Health and Men itam 27 is marka othar traumatic	_	19a. Informant's Name/Relationship (Type, P	rint)		19b. Mailin	g Address	(Street a	nd Numbe	r or Rura	l Route Numbe	r, City o	or Town, State, 2	Zip Code)
	D = 2 =		Francis W. Rye (Son)			1237	Hil:	1 Top	Dri	ve, Ann	apol	lis, MD	21401
ore	000		20a. Method of Disposition XIX Burial 2 ☐ Cremation 3 ☐ Remov	al from State	0	Place of Disposemetery, cren	natory or of	her place					ocation - City or	
Baltimore,	permit. Pag Department Important: I any injury o once.		`4 □Donation 5 □ Other (Specify)		Par	rk Hill	. Ceme	eter	y Nov	3, 2	2004	Mart	oury, Ma	aryland
Bal	permit. Pag Department Important: I any injury o		21. Signature of Funeral Service Licensee	mao	oen	22	. Name an	a Addres adri	For	y Lee ru D	Funeral	1 Hc	ome,Inc	6633 01d
			23a. Part1. Enter the disease, or complication	s that caused	the deat								Maryla	Approximate Interval Between
	Physician		shock, or heart failure. List only one car immediate Cause (Final disease or condition			secto	-, 1	ca	~	inc	ma			Onset and Death
	/Medical		resulting in death)	Due to (or as			<i>7</i> 01	(0)		, , , ,	0 4 (-)			
	Examiner	l.	Sequentially list conditions, b	See to form										
L	ted nsit	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Dus to (or as	a conseq	uenca on.								
	te be executed ysician and ie burial-transit	Examiner	that initiated events c. resulting in death) Last	Due to (or as	a conseq	uence of):							_	
190	cate be ohysicia the bur	call	d											
9			IF FEMALE:									-		
Вох	The law requires that the death certifica sie has been signed by the attending ph page 2 should be detached for use as th	Physician/Med	23b. Was decedent pregnant in the past 12 months?	yes, outcome ⊒Live birth	2 Feta	Ideath 3	Ectopic pro						23d. Date of del Month	ivery Day Year
0	at the de by the a stached f	ysic	1 Vec 2 No 4	□Pregnant a □Unknown	time of a	eatn 5∟	Other (sp	өспу)						
О.	that I	by Ph	Part II. Other significant conditions contribu	ing to death b	ut not res	ulting in the ur	nderlying ca	ause give	n in Part I.		23e. Did to	bacco u	use contribute to	the cause of death?
rds	w requires been sign should be		Anen	m 19							1 X Ý	es 2	□No 3□Pr	robably 4 Unknown
Records,	e law re has bed je 2 sho	Completed									24a. Was a		24b. Were au	utopsy findings available completion of cause of
H.		Com									perfor		death?	
Vital	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	al-				Otho			(Check only or			
of	Phys this ral dia	٠ <u>۲</u>	T THES ZELINO	a. Date of Inju		ER/Outpatien 28b. Time of		the same of	4 🗀 Nu		ne 5 Resid		6 □Other (Spec	cify)
on	Attanding I r death. actor: After by the funer	tlon	1 Accident 5 Pending investigation	(Month, Da	y Year)	Injury	м	8c. Injury Work 1 🔲 ۱	ເ?ົົ ∕es 2 🗍 I			,	,	
Division	or Attandi after death. Diractor: A in by the fu	Certification:	e Cloude not be	e. Place of In	ury · At he	ome, farm, stre	eet, factory	, office		2	28f. Location (S City or Tow			ural Route Number,
Ö	ital or A irs after ral Dirac led in by	Cert								1				
	To tha Hospital or Attani within 24 hours after deati To tha Funeral Diractor: completely filled in by the	edical	29a. Certifier (Check only one) 1 Certifying Physicial 2 Medical Examiner: 6	: To the best on the basis on and manner st	f examina	wledge, death tion and/or inv	occurred : estigation,	at the tim in my op	ie, date an pinion, dea	d place, a th occurre	and due to the c ad at the time, o	ause(s) late and	and manner as d place, and due	s stated. a to the cause(s)
	To the within To the comple	Me	29b. Signature and title of certifier	\$ 1			290		number	0.0		9d. Dai	te signed (Monti	
•				PM	<u> </u>			DI	164	18			10-31	04
(1.84		30. Name and address of person who complete Suresh A- Por	telin	ND	750	Print)	Sur	na-	HS F	Zel, C	117	nton,	m020735
	Sta	ite rar	31. Date filed (Month, Day, Year) NOV 0 3 2004	32. Projesti	ar's Signa	ature	South.							

			1 - For State Registrar			•	ne 2001 36617
	Physici /Medic Examir	cal	Decedent's Name (First, Middle, Las Mary Patricia \$ 4a. Facility Name (If not institution, give Holy Cross Hospita	Shipley street and number)	4b. City, Town, or Location of Silver Sprin	f Death	Day Year 2004 3. Time of Death 12:34 p M 4c. County of Death Montgomery
E	Funeral Director		5. Social Security Number 6. Sec. 053-18-1803 1 Usual Residence of Decedent	ex	If Under 1 Year If Under 2 Months Days Hours	Min (Month Day Ye	9. Birthplace (State or Foreign Country) West Virginia
	death with the Maryland ms 23a or 28a-f show rinust be notified at	Director	10a. State 10b. County	George's 10c. City, Town or Lo		100	10d. Inside City Limits N☐Yes 2☐No Citizen of What Country?
	3a or		5999 Emerson Str	eet	20710	, sag.	USA
	be filed within 72 hours after death with the Marylan Hygione. d other than "natural", or flems 23a or 28a-f show avant, 11-p Me Jigal Exama avant, 11-p Me	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	1 ∐Yes 2X No	Mas Decedent of Hispanic Original Yes, specify Cuban, Mexican, 1 ☐ Yes 2 ☒ No Specify:	gin? (Specify Yes or No- Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White
Maryland 21215-0036	filed within 72 hours after Hygiene. sthar than "natural", or Ite ant, Tre Nedical Examant	Completed	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12)	de completed) (Give	dent's Usual Occupation kind of work done during most DO NOT use retired)	of working	o. Kind of Business/Industry
N	filed w Hygier thar th		12 17. Father's Name (First, Middle, Last)	H	omemaker	r's Name (First, Middle, Maid	Own Home
and	d be fi	Be c	Clyde McKinney			Edna Hathaway	
<u> </u>	es 1 and 2 should be of Health and Menta filtam 27 is markad r other traumatic av	P	19a. Informant's Name/Relationship (7	Type, Print) 19b. Mailin	ng Address (Street and Numbe		
	and 2 ealth a n 27 is		Russell L. Shiple	ey, Jr Son 1536	Ellsworth Ave,	Crofton, MD	21114
w	of He of He or oth		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐	Removal from State 20b. Place of Dispo	natory or other place)		c. Location - City or Town, State
Baitimore,	permit, Pages Department of I Important: If It, any Injury or o		' 4 ☐ Donation 5 ☐ Other (Specify	Ft. Linco	In Cemetery 1		rentwood, Maryland
a n	permit Depar Impor any In		21. Signature of Fune al Service Licen	11/100	2. Name and Address of Facility	Gascii s Fui	neral Home, P.A.
Г	-			olications that caused the death. Do not entone cause on each line.			Approximate Interval Between Onset and Death
	-nysician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions.	a	estructive Pulmona	ary Disease	
	cuted nd ransit	Examiner	Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a cons ∗ uence of):			
68/60,	fficate be executed g physician and is the burial-transit	Ical	resulting in death) Last	Due to (or as a consequence of):			
O. Box 6	The law requires that the death certifical ate has been signed by the attending phoage 2 should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ▼ No 9 □ Unknown		Ectopic pregnancy Other (specify)		23d. Date of delivery Month Day Year
ds, F	uires that signed to lid be deta	b S	Part II. Other significant conditions of Large Bowel Of	ontributing to death but not resulting in the u	nderlying cause given in Part I.		co use contribute to the cause of death? 2 No 3 Probably 4X Unknown
Records,	: The law require cate has been si , page 2 should b	Completed				24a. Was an autopsy performed	
		a	25. Was case referred to medical		26. Place	1 ☐ Yes 2⁄⊠ of Death (Check only one)	No 1 Yes 2 No
	yslcian: iis certific director,	To B	examiner? 1 ☐ Yes 2X No	Hospital: 1 XInpatient 2 ☐ ER/Outpatier	it 3□DOA Other: 4□Nur	rsing Home 5 Residence	e 6 ☐Other (Specify)
Division of	or Attending Physician: ifter death. Diractor: After this certific in by the funeral director,		27. Manner of Death 1 □XNatural 5 □ Pending 2 □ Accident investigation		f 28c. Injury at Work? M 1 Yes 2 N	28d. Describe how in	njury occurred
DIVIS	tal or Attendrs after deati	Certification;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home, farm, str building, etc. (Specify)	eet, factory, office	28f. Location (Street City or Town, St	t and Number or Rural Route Number, tate)
	To the Hospital within 24 hours a To the Funaral C completely filled	Medical	(Check only 2 Medical Exen	ysicien: To the best of my knowledge, deat niner: On the basis of examination and/or in and manner stated.	n occurred at the time, date and vestigation, in my opinion, deat	d place, and due to the cause h occurred at the time, date	e(s) and manner as stated. and place, and due to the cause(s)
^	To T To t	Σ	29b. Signature and title of certifier	Lounni	29c. License number D38927	29d.	Date signed (Month, Day, Year)
e	6		30. Name and address of person who Philip Iorianni,	completed cause of death (Item 23a) (Type, MD 10810 Connectic	•	gton, MD 208	95
* i	Sta Regist	ate rar	31. Date filed (Month, Day, Year) NOV 0.5 2004	2. Registrar's Signature	A.		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death O- fores 28. 2004 **Physician** 10:55 Michael Evaston Smith /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's Doctor's Community Hospital Lanham If Under 1 Year Months Days If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 6. Sex Birthplace (State or Foreign Country) **Funeral** Min. 1**X** M 2□ F Hours Director 53 May 15, 1951 Virginia 224-78-4637 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2√ No Directo Prince George's Capitol Heights Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Itams 23a 7916 Beechnut Road 20743 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married ☐Yes 2 XNo ò Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: À If Yes, Give Year or Dates: Specify: Black 3 Widowed 4 Divorced "naturel" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 12 should ba filad within 7 h and Mental Hygiene.
7 is markad other then "r Elementary/Secondary (0-12) College (1-4or 5+) 11 Warehouse Safeway Company 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Mabel Coleman Lonnie Smith 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 sh
Department of Health and
Importent: If Item 27 is m
eny injury or other traum 7916 Beechnut Rd., Capitol Heights, MD 20743 Phyllis Dixon Sister 20a. Method of Disposition
1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Coleman Family Cem. Java, Virginia 4 ☐ Donation — 5 ☐ Other (Specify) 11/4/04 21. Signiture of Funeral Service Licensee 22. Name and Address of Facility
Miller Funeral Home, Inc. Ellmer P.O. Box 423, Gretna, Virginia 24557 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pnysician CARDIORESPIRATOR /Medical **Examiner** HEPATORENAL Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed use as the burial-transit DISEASE METASTATIC IVER and Due to (or as a consequence of) nding physician P.O. Box 68760. CANCE OLON Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 4□Pregnant at time of death 5 Other (specify) ed by the a detached f יייי שוויים הפונווומופ bas been signed by funeral director, page 2 should be detacl 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 2 3 No 1 🗌 Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No Yes Hospital or Attending Physicien: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 patient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural Injury 5 Pending s after decel Director: After 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Thomicide within 24 hours a t D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the 29d. Date signed (Month, Day, Year) 29b. Signature and little of certifier 4 30. Name and address of person who ompleted cause of death (Item 23a) (Type, Print) Landover Road, Cheverly MD 20783 NAYAR 6501

Registrar DHMH 17 Rev 1/2001

State

LIPISHRE 31. Date filed (Month, Day, Year)

0 3 2004

ni chael

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** October 30, 02:30 aM Williana Sorre11 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Kent Chester River Manor Chestertown 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
Jan. 12,1905 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country)
 VA **Funeral** Days Hours 1 ☐ M 2 🂢 F 99 Yrs. 215-24-8303 Director Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location If item 27 is marked other than "naturel", or Items 23a or 28e-1 show or other treumatic event, the McCloal Examinating the notified at 10d. Inside City Limits Director MD Queen Anne's Chestertown 1 ☐ Yes 2 📉 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 402 Pine Tree Road 21620 USA filed within 72 hours after death Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian. 1 Never Married 2 Married Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: Black Completed by 3 XWidowed 4 ☐ Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home permit. Pages 1 and 2 should be file Department of Health and Mental Hy Importaet: If Item 27 is marked othe any injury or other treumatic event, 2008. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be "unknown" Ezabel James Scott 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Howard Sorrell, Jr. 402 Pine Tree, Chestertown, MD 21620 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ACremation 3 ☐ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Cremation | Nov. 2, 2004 | Stevensville, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Fellows, Helfenbein & Newnam, P.A. 130 Speer Road, Chestertown, MD 21620 23a. Part1. Enter the disease, or come at ations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) CARDO pulmon um **Physician** /Medical Due to (or as a consequence of) **Examiner** nterioscures Sequentially list conditions. Examiner cause. Enter Underlying Cause (Disease or injury ng physician and as the burial-transit Hospitel or Attending Physicien: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records. P.O. Box 68760. the attending physician Completed by Physician/Medical IF FEMALE use 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy jo in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2 ☐ No detached 9 Unknown 9 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy 2∏ No 1 ☐ Yes 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 3 DOA this funeral 28a. Date of Injury (Month, Day Year) Certification: 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Injury 1 Matural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation within 24 hours after death To the Funerel Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 23889 30. Name and address of persop who completed cause of death (Item 23a) (Type, Print) 15 th Stuet, (Hestentown, Wed 21204 John C. ARRHBAL TR 223 710 31. Date filed (Month, Day, Year) 32. Regia State Registrar MOV 0 3 2004

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien [] 36650 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) ^{Day}2004 Oct. Year **Physician** 28, 21:45 M Mari Leishear Stover /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Chestertown Kent Chestertown Nursing & Rehab If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months Days Hours Min. | 5 ept. | 8,1922 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🗓 F 215-14-6871 MĎ Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "netural", or Items 23a or 28a-f show eny injury or other traumatic event, the M-dical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2X No Director KEnt Chestertown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 101 Morgenec Road #102B 21620 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Completed by 3 XWidowed 4 ☐ Divorced Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Government 12 Bookeeper 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Elsie Teague George W. Leishear, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linda Hartlove/Executrix 508 West Drive, Severna Park, MD 21146 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 XCremation 3 Removal from State Oct. 29, 2004 Stevensville, MD Chesapeake Cremation *4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Fellows, Helfenbein & Newnam, P.A. 130 Speer Road, Chestertown, MD 21620 Approximate Interval Between Onset and Death Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) COPD **Physician** /Medical Due to (or as a consequence of): Examiner Mess certice Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner The law requires that the death certificate be executed mo. page 2 should be detached for use as the burial-transit NES that initiated events resulting in death) Last the attending physician and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown signed by Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 DUnknown peeu 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an this certificate has autopsy performed? Yes 2 ours after death. Ierel Director: After this certifice filled in by the funeral director, p or Attending Physicien: 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 100 1 Inpatient Certification: To 1 Yes 2 ER/Outpatient 3□ DOA 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 5 Pending Natural 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 T Suicide 28e. Place of Injury - At home, larm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funerel L 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6602 OHURCH HILL DD FREDERICK 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene, 1 - For State Registra Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Shahan Year **Physician** October orac 6 12004 /Medical Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner hestertown If Under 24 Hrs. 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** 1 X M 2 □ F 79 218-20-6629 Director July 1,1925 PA Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits rai', or items 23a or 28a-f show 1 Tes 2 No MD Worton Kent Director 10g. Citizen of What Country? 10e, Street and Number 10f. Zip Code 21678 USA 25199 Still Pond Neck Road death Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status permit. Pages 1 and 2 should be illed within 72 hours after c Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural; or Iten any injury or other traumatic event. If a Medicul Exam and Black, White, etc. ☐Yes 2∑No f Yes, Give 1 Never Married 2 Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) -0-Construction Construction 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Lulu Matilda Dixon Horace GEorge Shahan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 220 Clarks Corner Rd, Centreville, MD 21617 Jeff Shahan 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Wesley Chapel Cemetery Oct.30,2004 Rock Hall, MD * 4 ☐ Donation 5 ☐ Other (Specify) 131 Speer R. Chestertown, MD Fellows, Helfenbein a Newham, 21. Signature of Funeral Service Licenses 23a. Part1. Enter the disease, or compiliations that clused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician CONGESTIVE HEART /Medical Due to (or as a consequence of): **Examiner** ARTERY ORONARY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Dav Year Month 4 Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ PULMUNARY DISEASE 1 Yes 2 No 3 Probably 4 Unknown STRUCTIVE Completed peen 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an has certificate 2 🔯 No 1 ☐ Yes the Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 2 ER/Outpatient 3□ DOA After this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: 1 Natural
2 ☐ Accident Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation Director: in by the 6 Could not be determined 3 T Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours after To the Funeral Dire Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number D004158 homo 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Helen Noble, 122 Speer Road, Chestertown, MD 21620 31. Date filed (Month, Day, Year) 32. Registrar's Signature State OCT 2 9 2004 Registrar

ORIGINAL

			For State of I	Maryland / Departr Certifi	ment of Health an	d Mental Hy	giene 004	36652
	Physici	an	Decedent's Name (First, Middle, Last)		141.	2. Date of De		3. Time of Death 2250 M
	/Medic Examin		a. Facility Name (If not institution, give street and numb		. City, Town, or Location of D	Death Control	4c. County of Death	220
			MCMONI AI HOSPLAJ A i. Social Security Number 6. Sex 7.	Age (In yrs. last birthday)	USTON Under 1 Year If Under 24	Hrs. 8 Date of Bir	1allot	lace (State or Foreign
	Funeral Director		217-03-1121 10M 200/F			Hrs. 8. Date of Bir (Month, Da		ry/and
1	yland	_	Jsual Residence of Decedent Oa. State 10b. County	10c. City, Town or Location	non		11	Od. Inside City Limits
3	ith the Marylar or 28a-f show	Director	MD Talbot	Belle	VUE Of. Zip Code		10g. Citizen of What Coun	1 1 1 Yes 2 No
El	death with the Maryland ms 23a or 28a-f show	ai Dir	25820 Orchard 7	<i>-</i>	21662	ا ر	USA	uy:
1 10	ë ≅ ≅	Funeral	11. Marital Status 1 □ Never Married 2 □ Married 1 □ Ves 2	TNo	Decedent of Hispanic Origin s, specify Cuban, Mexican, F	? (Specify Yes or No Juerto Rican, etc.)	14. Race - Americ Black, White,	
21 C		by	3 ☑ Widowed 4 ☐ Divorced If Yes, Give Year or Date	9S:	Yes 212 No Specify:		Specify 1ac	
215-	hin 72 e. en "nat Medic	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4	(Give kind life. DO I	s Usual Occupation fof work done during most of NOT use retired)	_	16b. Kind of Business/Inc	lustry
J, (filed with Hygiene. other ther ent, It e M		7. Father's Name (First, Middle, Last)	Produ	ction Line 1	Worker Name (First, Middle		industry
inith, Mazic Maryland 21215-0036	2 should be filed within and Mental Hygiene. Is marked other then raumatic event, It a Market	To Be	John Edward	Thomas	1		Fleming	
Smith, Ma Maryland 2121	s 1 and 2 should be filed within 72 h I Health and Mental Hygiene, item 27 Is marked other then "natu other traumatic event, the Madical		19a. Informant's Name/Relationship (Type, Print)		ddress (Street and Number of 7-SK; pton-C			•
	permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other tra		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from Sta	cemetery, cremato	n (Name of ry or other place)	Date	20c. Location - City of To	wn, State
altimore,	nit. Pag artment ortant: injury o		*4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee	Richarde	Mem, Park	1-2-04	Easton, Me	aryland
Ba	permi Depa Impo any ir		Janelle C. He	may 510	me and Address of Facility NRY FUNERS Washingto	N St. Cal	ubridge M	D.21613
			23a. Part Cnter the disease, or complications that cau shock, or heart failure. List only one cause on eac Immediate Cause (Final	sed the G eath. Do not enter th h line.	e mode of dying, such as cal	rdiac or respiratory a	rrest,	Approximate Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	as a consequence of):				
	Examiner	er	Sequentially list conditions, from leading to immediate cause. Enter Underlying Cause (Disease or injury	as a consequence of:	nt Failure	(Diast	olic Dystu.	nction
	ecuted and transit	Examiner	nat initiated events c.	as a consequence of):				
8760,	sate be executed hysician and the burial-transit	dicai E	d	as a consequence of).				
9	leath certifica attending ph I for use as th	a a	IF FEMALE: 23c. If yes, outco	me of pregnancy			00 / 5 / / / /	
Box.	death o	Completed by Physician/M	in the past 12 months? 1 Ves 2 No	n 2 ☐ Fétal déath 3 ☐ Ecti it at time of death 5 ☐ Oth	opic pregnancy ner (specify)		23d. Date of delive Month	ry Day Year
Θ.	res that the de signed by the a l be detached f	Phys	9 ☐ Unknown 9☐ Unknown Part II. Other significent conditions contributing to deat		lying cause given in Part I.	23e. Did t	obacco use contribute to th	e cause of death?
ords,	w requires been sign should be	ted by	Non Insulin dep	endant [Sighetes	11	Yes 2 □No 3 □ Proba	ably 4 Wiknown
Seco	ne law re has be ge 2 sho	mple				24a. Was	an 24b. Were autoposy prior to comped?	osy findings available apletion of cause of
ta	iician: Th certificate rector, pag	a)	25. Was case referred to medical		26. Place of	1 ☐ Yes Death (Check only of	2 No 1 ☐ Yes	2 □ No
of V	Physical this certain direct	To B					dence 6 Other (Specify)
ion	ath. rr: After	ation	↑ Natural 5 Pending (Month, 2 Accident investigation		28c. Injury at Work? U 1 ☐ Yes 2 ☐ No	Zod. Describe	now injury occurred	
Division of Vital Records, P.O.	or Atte after de Directo in by th	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of building	Injury - At home, farm, street, etc. (Specify)	factory, office	28f. Location (: City or Tox	Street and Number or Rural wn, State)	Route Number,
_	Hospita 4 hours Funerel ely fillec	Medical Co	29a. Certifier 12 Certifying Physicien: To the basion one) and mannei	s of examination and/or investi	curred at the time, date and p gation, in my opinion, death o	lace, and due to the occurred at the time,	cause(s) and manner as sta date and place, and due to	ited. the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier		29c. License number		29d. Date signed (Month, L	Jay, Year)
			30. Name and address of person who completed cause	of death (Itam 23a) (Time Prin	000531	10	10/29/20	04
			Dennis DeShields, 219 S.			21601	71 100.1	
	Sta Registr		31. Date filed (Month, Day, Year) NOV 0 1 200 Reg					

Mark Eric Shaw 04-06991 crn

מ			For State Registrar		State o	f Marylar		artment rtificate				lental Hy	giene Reg. Nd.) ()) () ()	2000
	Physicia		1. Decedent's Name MARK ERIC		ast)							2. Date of De Month	Day	Year	Cule off of the
	/Medic Examin	al	4a. Facility Name (If I		ve street and nur	nber)		4b. City,	Town, or	Location of	of Death	Octobe		2004 inty of Death	3:00 P ™
1	Examin	e i	8 Ashmo							Spr	ina		M	Iontaan	ierv
	Funeral	- 1	5. Social Security Nu	mber 6.	Sex Maria Maria 2□ F	7. Age (In yrs.	last birthday) Yrs.	If Under Months		If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, Da AUGUST 2	th y Year)	9. Birthr	place (State or Foreign
	Director	-	216-74-565 Usual Residence of D	00		45	115.					AUGUSI Z	8, 1959	WASHI	NGTON, D.C.
	with the Maryland is or 28a-f show	_		10b. County			ty, Town or Lo		_	_			_	1	Od. Inside City Limits
	vith the Maryland or 28a-f show be notified at	ecto	MARYLAND	MONTGOM	IERY	S	ILVER						10 011		1 X Yes 2 □ No
	th with t	Dir	#8 ASHMON					10f. Zip	0906					of What Cour D STAT	
	dea ea	Funeral Directo	11. Marital Status		12. Was Dece Armed Fo	ident Ever in U	I.S. 13.	Was Deced	lent of Hi	spanic Ori	gin? (Spe	ecify Yes or No Rican, etc.))- 14. [Race - Americ Black, White,	
36	hours after o tural', or Iter al Examinat	by Fu	1 ☐ Never Marrie		1 XYes If Yes, Giv Year or D	^{2□No} t9	QQ-	1 ☐ Yes 2		Specify:					ACK
21215-0036	n 72 hours "natural", edical Exa			15. Decedent's E	Education	ates.	16a. Dece	dent's Usua	I Occupa	ation			16b. Kind o	of Business/In	
215	C . 38	Completed	(Specify Elementary/Second	dary (0-12)	4 YEARS	-4or 5+)	life.	kind of wor DO NOT us	e retired,	furing mos)	t of worki	ng	DUC	TMECC	
121	a filed within I Hygiene. other than	Co	17. Father's Name (F	First Middle Las			ACC	OUNTA	NT	18 Mothe	ar's Name	(First, Middle		INESS	
Maryland	s 1 and 2 should be filed within f Health and Mental Hygiene. Item 27 is marked other than other traumatic event. Item	To Be	OTHA SHAW							LUCI	LLE	L. WIL	LIAMS	SHAW	
Mar	od 2 sh Ith and 27 Is rr traum		19a. Informant's Nar					_				Route Number		-	20906
Je,	es 1 and 3 of Health fitem 27 ir other tr	İ	20a. Method of Dispo				Place of Dispo cemetery, cre	osition (Nam	ne of ther place	9)	C	ate	20c. Location	on - City or To	own, State
Baltimore,	Page: ment o tant: If jury or		'4 □Donation 5		□Removal from	HAR	MONY MEN	ORTAL 1	PARK	N	OVEMB	ER 5,200	4 HYATT	'SVILLE	E, MARYLAND
Ball	permit. Pages Department of Important: If i any injury or once.		21. Size ture of Fun LYDIA (1.00	TON JOH	NSON MO	0583 T	HÖRNT 439 L	ÓÑ'F IVIN	UNERA GSTON	L HO	ME, P.A.D, IND	A. IAN HE	AD, MAI	RYLAND 20640
ı				t failure. List onl	mplications that c y one cause on e	aused the dea ach line.	th. Do not en	ter the mode	e of dying	g, such as	cardiac o	r respiratory a	rrest,		Approximate Interval Between Onset and Death
	Priysician /Medical		Immediate Cause (F disease or condition resulting in death)	-inal	a PULM	or as a conse	171	rome	506	MISO	2613	M		_	
Н	Examiner				DET		EU V	EW	TR	trot	1150	sis			
_	Po ∺	iner	Sequentially list conditions, leading to immoduse. Enter Underlicause (Disease or in	mediate lying		or as a conse	quence of):								
•	ate be executed hysician and the burial-transit	Examine	that initiated events resulting in death) La		c	or as a conse	quence of):								
8760,	ate be enthysician	dicai E			d										
9	artificat ing phy e as th	Medi	IF FEMALE:												
Вох	eath certific attending p	hysician/Me	23b. Was decedent in the past 12 n	nonths?		come of pregn inth 2 ☐ Fet ant at time of	al death 3[⊒Ectopic pro					23d.	Date of delive Month	ery Day Year
0	by the datached	nysic	1 □ Yes 2 □ 9 □ Unknown	No	9□Unkn		Jean 5	_ Other (spi	6CII Y)		· · ·				
<u>α</u>	The law requires that the death certific te has been signed by the attending p bage 2 should be detached for use as	by Pi	Part II. Other signific	cant conditions	contributing to de	eath but not re	sulting in the u	inderlying ca	ause give	en in Part I					ne cause of death?
ord	w require been si should I											10			ably 4 Unknown
Vital Records,	ne law has b ge 2 sl	ompieted										24a. Was autor	an 24 osy ormed?	b. Were auto prior to con death?	psy findings available mpletion of cause of 2 No
E	(2)	e Co	25. Was case referre	ed to medical	<u> </u>					26 Place	of Death	1 Yes		1 Yes	2 No
ίŽ	di S	To B	examiner? tX Yes 2 ☐ N		Hospital: 1 🔲	npatient 2] ER/Outpatie	nt 3 DO	A Othe					Other (Specify	at scene
n of	ding Ph		27. Manner of Death	5 Pending		of Injury th, Day Year)	28b. Time o		8c. Injury Work	(?		28d. Describe	how injury oc	curred	
Division	Attending r death. ector: After by the fune	ficat	2 Accident 3 Suicide	investigati	ho .	of Injury - At h	ome, farm, st	M reet, factory		res 2□		28f. Location (Street and Nu	ımber or Rura	I Route Number,
Ω̈́	al or Attences after death	Certification:	4 Homicide	determine	buildi	of Injury - At h ng, etc. (Speci	fy)		,			City or Tox	wn, State)		
	Mospital or 24 hours after 6 Funeral Direction filted in blately filted in b	ledical (29a. Certifier (Check only one)	1☐ Certifying F	Physician: To the aminer: On the band man	best of my kn asis of examin ner stated.	owledge, deat ation and/or in	h occurred avestigation,	at the tim	ie, date an pinion, dea	d place, a th occurr	and due to the ed at the time,	cause(s) and date and plac	manner as st e, and due to	tated. the cause(s)
	To the Hos within 24 h To the Fur completely	Me	29b. Signature and t	title of certifier	n .1.			29c		number				ned (Month,	
			▶ Illa	Works !	Ine yn	ul 1	10		0.	C.M.I	Ε.		Octob	er 30,	2004
_/	8321		30. Name and addre	IN A	KORE	u	11	1 Penr		reet,	Bal	timore,	Mary	Land 21	1201
	Sta Registr		31. Date filed (Month	NOV 03	2004 32. F	gistrar's Sign	ature A	book	,						

DHMH 17 Rev 1/2001

Registrar

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			1 - For State Ragistrar	State of Mar		artment o				jiene ag. N2 ()	NL	36655
	Physici		Decedent's Name (First, Middle, Las Kevin Edwa	•	mpson	Jr.			2. Date of Dea Month		Year	3. Time of Death /650 M
	/Medi Examir		4a. Facility Name (If not institution, give PENNS4/h AND No. 5. Social Security Number 6. S	street and number)		4b. City, To	SALIS	cation of Death			ty of Death	7//0 place (State or Foreig
	Funeral Director			∑ M 2□ F	Yrs.		Days H	ours Min. 1 6	8. Date of Birth (Month, Day 10/26/	, Year) 0 4	Cou	ryland
	within 72 hours after death with the Maryland ane. than "neturel", or items 23e or 28a-1 show is Nacical Examiner must be notified at	ral Director	10e. Street and Number 802 Priscilla	omico St.		isbury 10f. Zip Co	ode 0 4			0g. Citizen of	What Cour	
9-0036	in 72 hours after de "neturel", or item: lodical Examiner	ted by Funeral	11. Marital Status 1 ☑ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Ec	12. Was Decedent Ev. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	16a. Dece	If Yes, specify 1 ☐ Yes 2 dent's Usual C	Cuban, M No Sp Occupation	lexican, Puerto				etc. .ack
21215-0036	- E	Completed	(Specify only highest gra	College (1-4or 5+) n/a	life.	n/a	retired)	g most of work		n/a		
Maryland	o d a b	To Be	17. Father's Name (First, Middle, Last) Kevin Edwasrd	Thompson				Rah	(First, Middle, manda	Das	hiel:	
	s 1 and 2 should if Health and Mer item 27 is marke other treumetic		19a. Informant's Name/Relationship (1) Rahmanda Dashi		r 802	Priso	cilla	a St.,	Salisb	ury,Ml	D 218	304
Baltimore,	t. Page rtment o rtent: If rjury or		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	<i>'</i>)	Salisbur	matory or other Y Cre 2. Name and A	n <i>r place)</i> mato Address of	ry 1	1/1/04		sbur	y, MD
ă	permi Depa- Impo any ii		23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final	olications that caused th	- F-SP	<u>501 Sr</u>	l wor	Hill R	dSal	isbury	essic y , MD	nal Asso 21804 Approximate Interval Between Onset and Death
8760,	icate be executed /Medical bhysician and sthe burial-transit	dical Examiner	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate acase. Enter thickning Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a o	consequence of):		ou					
O. Box 6	The law requires that the death certificate be executed to has been signed by the attending physician and toge 2 should be detached for use as the burial-transit	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ⑤ No 9 □ Unknown	23c. If yes, outcome of 1 □ Live birth 2 l 4 □ Pregnant at tin 9 □ Unknown	Fetal death 3	⊒Ectopic pregr ⊒ Other (s <i>peci</i>					ate of delive	ery Day Year
rds, P.	w requires that been signed b should be deta	by	Part II. Other significant conditions c	ontributing to death but of	not resulting in the u	underlying caus	se given in	Part I.		oacco use con		ne cause of death? ably 4 □Unknown
Vital Records,		Completed					-		24a. Was a autops perform	y	Were auto prior to cor death? 1 \(\sum \text{Yes}	psy findings available inpletion of cause of
Zi zi	Physicien: this certifica al director, p	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital:	2 ☐ ER/Outpatie				(Check only on			
ion of	ing After unea	H-	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Y	A STATE OF THE PARTY OF THE PAR		Injury at Work?		me 5 □ Reside 28d. Describe ho			/)
Division		Certification:	3 Suicide 6 Could not be determined	building, etc. (Specify)				28f. Location <i>(St</i> City or Towr	, State)		
	To the Hospital or within 24 hours after To the Funeral Dir completely filled in	ledical	one) 2 Medical Exam	ysician: To the best of endinger: On the basis of endinger: and manner state	(amination and/or in	ivestigation, in	my opinior	n, death occurr	ed at the time, da	ate and place,	and due to	the cause(s)
)	To To com	Σ	29b. Signature and title of certifier Mucuas / J.	Cree mg		3	58	578		9d. Date signe		Day, Year)
			30. Name and address of person who	completed cause of deal	th (Item 23a) (Type,	Print) Salis	busy	10 21	1801			
: (Sta Regist		31. Date filed (Month, Day, Year)	32. Registrar's	Signature	Spo	nks	/				

Baby Boy Rahmanda 0 45hieil

State of Maryland / Department of Health and Mental Hygiene 1- State Registrar AMEND ITEM #5 PER FH C837 1 Petificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death **Physician** Mary Madeline Towler October 28,2004° 23:57 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** Southern Maryland Hospital Clinton Prince Georges If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days 1 ☐ M 2 🔯 F Yrs Director March 3,1928 Maryland Usual Residence of Decedent 10a State 10b Counts 10c, City, Town or Location 10d. Inside City Limits item 27 is marked other than "neturel", or itams 23a or 28a-f show other treumatic event, the Modical Examiner must be notified at XXYes 2 □ No Director Maryland Charles Waldorf 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9630 Jermaine Place 20603 USA Funeral 12. Was Decedent Evar in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Maxican, Puerto Rican, etc.) 14. Race - American Indian. a filad within 72 hours after de I Hygiene. other than "neturel", or Itam Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√ No by Specify: Specify: Black 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Domestic 12 should ba filad wi h and Mental Hygien 7 Is marked other th 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Howard Proctor Cecelia Proctor 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) is 1 and 2 s of Haalth an item 27 Is Betty Simms/ Daughter 9630 Jermaine Place Waldorf, Maryland 20603 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pagas Department of Important: If it any injury or or to XXBurial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) St. Peters Ch Cem 11/6/04 Waldorf, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility ()desoa MO1323 Adams Funeral Home P.A. Aguasco, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Houte Physician MI disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner on the mia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner burial-transit whire that initiated events resulting in death) Last Due to (or 🍰 a consequence of): attending physician Box 68760 certificate be Physician/Medical the as IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 1 ☐ Live birth 2 ☐ Fetal death in the past 12 months? Month Day 4 Pregnant at time of death 5 Other (specify) P.O. the a signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. þ Lailure 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has 2 **X** No 1 ☐ Yes the Hospitel or Attending Physicien: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 XNo 1XInpatient 2 ER/Outpatient 3 DOA ၉ this 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After 5 Pending investigation 1 Natural Injury death. 2 Accident Director: 6 Could not be determined 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier cal (Check only one) and manner stated 29c. License number 29b. Signature and title of certifier 2 D0053219 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TEPOST Office Road, Waldorf, MD 20602 ANSARI, MD 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1 Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** CLARICE K. UGAS OCTOBER 31, 12:02 A M 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 3 ROYAL FOREST COURT SILVER SPRING MONTGOMERY If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Birthplace (State or Foreign Country) 1 □ M 2 X F Days Director 075-16-6953 82 JUNE 29. 1922 NEW YORK Usual Residence of Decedent with the Maryland show 10b. County 10c, City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any highly or other traumatic avant, it e Madical Examinar insist be multilised and proce. 1 X Yes 2 No MARYLAND MONTGOMERY SILVER SPRING Direct 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 3 ROYAL FOREST COURT 20904 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: ğ 3 ☐ Widowed 4 X Divorced Specify: WHITE Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) 12 PAYROLL SUPERVISOR FEDERAL GOVERNMENT 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) DAVID **EPSTEIN** CAROLYN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MICHELLE R. UGAS/DAUGHTER 3 ROYAL FOREST COURT, SILVER SPRING, MD 20904 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) NATIONAL CREMATORY 11/2/2004 FALLS CHURCH, VIRGINIA 22. Name and Address of Facility
DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC.
1170 ROCKVILLE PIKE, ROCKVILLE, MD 20852 21. Signature of Funeral Service Licenses Inanda 23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician RESPIRATORY FAILURE 1 YEAR disease or condition resulting in death) /Medical Due to (or as a consequence of). **Examiner** PNEUMONIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine attending physician and for use as the burial-transit certificate be executed Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗙 No Day Month Year 4 ☐ Pregnant at time of death 5 Other (specify) P.O. the detached 9 Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. ģ CHRONIC RENAL FAILURE Completed 1 ☐ Yes X ☐ No 3 ☐ Probably 4 ☐ Unknown been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy rmed? 2 X No 1 ☐ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Diractor: After this certifies Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home X Residence 6 Other (Specify) P 1 X Yes 2 □ No 1 Inpatient 2 ER/Outpatient 3 DOA funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of Certification: 28d. Describe how injury occurred 5 Pending investigation М 1 ☐ Yes 2 ☐ No 2 Accident the 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 1735/03 8 NOVEMBER 1, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) STEPHEN VACCAREZZA, M.D., 6240 MONTROSE RD., ROCKVILLE, MARYLAND 20852 31. Date filed (Month, Day, Year) 32. Registrar's Signature

DHMH 17 Rev 1/200

State

Registrar

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death Ta'Niyah Elizabeth Dashea Vaughan 21,2004 August 2220 4c. County of Deeth 4a Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death Sinai Hospital Baltimore City If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months 1 ☐ M 2 🗓 F 2004 Maryland August Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 ☐ Yes 2 1 No Maryland Baltimore Owings Mills 10e. Street end Number 10g. Citizen of What Country? 251 Cedarmere Circle 21117 USA 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Maritel Status 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No If Yes, Give X 1 ☐ Yes 2X No Specify: Black Specify 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 0 Infant 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Jerwon Vaughan Crystal Charmaine Barber 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 251 Cedarmere Circle Owings Mills M) ce of Disposition (Name of Date 20c. Location - City or Town, Stale Crystal Barber/Mother MD 21117 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ (Specify) Sinai Hospital Baltimore, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Sinai Hospital 2401 W. Belvedere Ave Baltimore, MD 21215 25a. Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on eech line. Approximate interval Between Onset and Death Immediate Cause (Final Promoturity

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23s or 28s-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020

Be Completed by Funeral Directo

Medical Certification: To Be Completed by Physician/Medical Examiner within 24 hours efter death.

To the Funeral Director: After this certificate hes been signs completely filled in by the funeral director, page 2 should be

the Hospital or Attending Physician: The law requires that the deeth certificate be executed Division of Vital Records, P.O. Box 68760,

resulting in death)	a. I Tellia cui	LLY			22 min.
rosulting in country	Due to	or as a consequence	of):		
	Pre-term	labor			1
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying		or as e consequence	of):		
Ceuse (Disease or injury that initiated events resulting in death) Last	c Due to (or as a consequence	of):		
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Part II. Other significant conditions	contributing to dooth but not ro	culting in the underlyin	a souse given in Deat I	22h Did tobassa usa sa	entribute to the cause of deeth?
ratti. Other significant conditions	contributing to death but not re	sutting in the underlyin	g cause given in Fait i.	23b. Did tobacco use co	ontribute to the cause of deeth?
				1 ☐ Yes 2 📈 No	3 Probably 4 Unknown
				24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
				1 □ Yes 2 X No	1 ☐ Yes 2 汉 No
25. Was case referred to medical examiner?			26. Place of D	eath (Check only one)	
1 Ves 2 No	Hospital: 1 y Inpatient 2	ER/Outpetient 3□	DOA Other: 4 Nursing	Home 5 ☐ Residence 6 ☐ Oth	ner (Specify)
27. Manner of Death 1 ☑ Naturel 5 ☐ Pending 2 ☐ Accident investigat	28e. Date of Injury (Month, Dey Year)	28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how injury occur	rred
3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine		nome, farm, streel, fac	tory, office	28f. Location (Street and Numb City or Town, State)	ber or Rural Route Number,
29a. Certifier 1 Certifying F (Check only one) 2 Medical Exp	Physician: To the best of my known aminer: On the basis of examinating and manner stated.	owledge, death occurration and/or investigat	ed et the time, date and plac ion, in my opinion, death occ	ce, and due to the ceuse(s) and me curred at the time, date and place,	enner as stated. and due to the cause(s)
29b. Signature and title of certifier			29c. License number	29d. Date signe	ed (Month, Day, Year)

29c. License number

P17500

30. Name end address of person who completed cause of death (Item 23a) (Type, Print) Ruth Merid MD

Sinai Hospital 2401 W. Belvedere Baltimore, MD 21215

31. Dete filed (Month, Day, Yeer)

32. Registrar's Signature

Registrar

1. Decedent's Name (First, Middle, Last)

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Physician

State of Maryland / Department of Health and Mental Hygienes

Certificate of Death

Reg. No.

2 Date of Death

Month

3. Time of Death

Registrar

NOV n 1 2004

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	Examir	ier	4a. Facility Name (If not institution, give			4b. City, Town, o	or Location of Death		4c. County	
			Salisbury Nursing				Salisbur		Wico	mico
	Funeral		Social Security Number 6. Security Number		rs. last birthday) Yrs.	Months Days	If Under 24 Hrs. Hours Min.	(Month, Da)	/, rear)	Birthplace (State or Foreige Country)
	Director		151-28-2712 Usual Residence of Decedent	□ ^{M 2} M ^F 90	115.			December	7, 1913	New Jersey
	and		10a. State 10b. County	10c.	City, Town or Loc	ation				10d. Inside City Limits
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	the #	Director	Pennsylvania Luzern	е	Forty I	10f. Zip Code			10g. Citizen of	
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	ter d Item	'n	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2X No	lf.	Yes, specify Cub	Hispanic Origin? (Spean, Mexican, Puerto	Rican, etc.)	Bla	ck, White, etc.
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215	c * 6	Completed	(Specify only highest gra Elementary/Secondary (0-12)	de completed) College (1-4or 5+)	(Give k	rind of work done O NOT use retire	during most of worki	ing		,
212	filed within Hygiene.	EO	12.	4	Teach	er			Educa	ation
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Maryland 21215-0036	d 2 should th and Mer 7 is marke treumetic	_	19a. Informant's Name/Relationship (7			Address (Street	and Number or Rura		r, City or Town,	
	alth alth 27 is		David Williams	(son)	4414 5	Sunset Di	rive, Tyas	kin Ma	rvland	21865
ē,	es 1 and of Healt fitem 2 r other		20a. Method of Disposition	20b	. Place of Dispos	ition (Name of atory or other pla				City or Town, State
Baltimore,	Pag ent nt: i		1 ☐ Burial 2 XI Cremation 3 ☐ 14 ☐ Donation 5 ☐ Other (Specify		-		´ 1	er 2.2004	Salich	oury, Maryland
=	permit. Pa Departmen Importent: eny injury		21. Signature of Funeral Service Licen	see See						al Association
m	Depa Impo eny i		1 / De Black	BARN MES						aryland 21804
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only	olications that caused the de	ath. Do not ente	r the mode of dying	ng, such as cardiac o	r respiratory arr	est,	Approximate
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7	/Medical		disease or condition resulting in death)	a. Due to (or as a cons	1	1019	- Wee	20		gloca
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o,	certificate be execuiding physician and ise as the burial-tran		resulting in death) Last	Due to (or as a conse	equence of):					
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Вох	ath certifii tending p or use as	N/	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of preg 1□Live birth 2□Fe					23d. Da	te of delivery
	de de de de de de de de de de de de de d	icia	in the past 12 months? 1 Yes 2 No	4☐Pregnant at time of		Other (specify) _			Мо	nth Day Year
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ă	afte Dire	Certification;	4 Homicide determined	building, etc. (Spec	cify)			City or Town	i, State)	
	Hospitel	a	29a. Certifier 1 Certifying Phy	ysician: To the best of my ki	nowledge, death	occurred at the tir	ne, date and place, a	and due to the ca	ause(s) and ma	nner as stated.
	To the Hospitel or Attend within 24 hours after death To the Funerel Director: completely filled in by the	edical	(Check only 2 Medical Exam	iner: On the basis of examinand manner stated.	nation and/or inve	estigation, in my o	pinion, death occurre	ed at the time, da	ate and place, a	and due to the cause(s)
	To th withir To th	Me	29b. Signature and title of certifier	11)		29c. Licens	e number	25	9d. Date signed	i (Month, Dey, Year)
			MATH	Tien .		0	2954	9	11/11	9
5)		30. Name and address of person who d	completed cause of death (Ite	em 23a) (Type, P	rint)	- / /		1 / 0	
DO	X	1	William H.R				00 Civic	Ave. Sal	lishury	, Md. 21804
								u.	y	, .M. CTOOT

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

NOV 03 2004

1 _ State

32. Registrar's Signature

				State of Maryland / I	Department of Health Certificate of Deatl		giene 2 (04	36662
	Physic		1. Decedent's Name (First, Middle, Last)	Vators		2. Date of D Month		Year	3. Time of Death
	/Medi Examir		4a. Facility Name (If not institution, give st	reet and number)	4b. City, 1	Town, or Location of Dea	th 4c. Count	2004 v of Death	2 17/10 m
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	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last bir		or 24 Hrs. 8. Date of B	rth		ce (State or Foreign
	Director		270-32-7892 10	M 22 F 69	Yrs. Months Days Hours	Min. (Month, D	ay, Year) 15-35	Country	mp
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	s 23c	<u>ra</u>	421- JEFFER		21801			USA	
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20	filed within 72 hours after death with the Maryland Hygiene. ther then "neturel", or items 23a or 28e-f show ont, the Medical Examiner must be notified at	by Funeral Director	Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:	1 ☐ Yes 2 No Specify	y:	Specif	y: RI	ACK
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215	hin 7.	Completed	(Specify only highest grade Elementary/Secondary (0-12)	completed) College (1-4or 5+)	Decedent's Usual Occupation (Give kind of work done during mo life. DO NOT use retired)	st of working		^	,
21	d with giene. or ther	ĕ	12	College (1-401 54)	LINEWORKER	R	MASON	15 CF	INNERY
5	be filed tal Hygi d other event, t	Be	17. Father's Name (First, Middle, Last)		18. Moth	ner's Name (First, Middle	, Maiden Surnan	ne)	1
Maryland	d 2 should be filed within 72 hours after death with the Marylan th and Mental Hygiene. T is marked other then "neturel", or items 23a or 28e-f show treumatic event, the Medical Examinar must be notified at	2	EDWARD W	ATERS	K	ATIE U	//LSDA	J	
ar	2 sho and is me		19a. Informant's Name/Relationship (Type	e, Print) 19b	Mailing Address (Street and Numi	ber or Rurel Route Numb	er, City or Town,	State, Zip Co	ode)
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ore	S to E		20a. Method of Disposition 1 ▶ Burial 2 □ Cremation 3 □ Rei	comoto	Disposition (Name of y, crematory or other place)	Date	20c. Location -	City or Town	, State
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	/Medical Examiner		Immediate Cause (Final disease or condition resulting in death) a.	Congestive	Keart failu	rs.		2	2 days
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E	e dea the et	sici	Part II. Other significant conditions contri	buting to death but not resulting in	the underlying cause given in Part	I. 23b. Did	tobacco use cor	ntribute to th	e cause of deeth?
P.O.	The law requires that the death certifiate has been signed by the ettending page 2 should be detached for use as		Stole TO SUCY	al docubitu	s ulcar	1 🗆	Yee 2 No	3 Probab	iy 4 🗌 Unknown
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of	Phys rthis aral d	- 1		Inpatient 2 ER/Out 28e. Date of Injury 28b. T	patient 3LIDOA 4LIN	ursing Home 5 Resi	dence 6 LiOthe how injury occurr		
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Division of Vital Records,	Atter ar dea ector by th	<u></u>	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At home, far	m, street, factory, office		Street and Numb	er or Rurel Ro	oute Number,
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	To the within 2 To the comple	Med	one) 29b. Signature and title of certifier	and manner stated.	29c. License number		29d. Date signed		
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			30. Name and address of person who com	pleter cause of death (Item 23e) (Type Print)	,	//		
D	\mathbb{Q}			1.0 PO B	0x 2018, Salis	bury, r	10 2	1802	
	Sta Registr	~	31. Date filed (Month, Day, Year) NOV 03 200	32. Registrar's Signature	Type. Print) OX 2018, Salis B Space				
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			1 - For State Registrar	State of Ma	aryland		artment rtificate			and M	ental Hy	giene		200	(1)
I			1. Decedent's Name (First, Middle, Las	st)							2. Date of De		Year	3. TMe 9	Death
	Physici /Medic		Norman E.	Warner							Octobe		2004	10:33	РМ
	Examin		4a. Fecility Name (If not institution, give				,		Location o	of Death			County of Death		
			Shady Grove Adve		pital e (In yrs. Ia	st highday)	Roc If Under	kvi.	Lle If Under 2	24 Hrs.	8 Date of Bir		ontgome		- Foreign
	Funeral Director			XIM 2□F	83	Yrs.	Months	Days	Hours	Min.	8. Date of Bi (Month, Da April	ay, Year)	21 Iowa	place (State o	rroreign
	ס		Usual Residence of Decedent								тргтт	., .,			
	show	Ļ	10a. State 10b. County	. 2017		Town or Lo								10d. Inside Cit 1 X Yes	-
	Ba-f	Director	Maryland Montgome	:L y	Ga	ithers									2 NO
	with t	ā	10e. Street and Number 333 Russell Aver	nue #522			10f. Zip)877					en of What Cou ted Sta	-	
	ns 23	era	11. Marital Status	12. Was Decedent	Ever in U.S	S. 13.1			spanic Orig	gin? (Spe	cify Yes or No Rican, etc.)		4. Race - Amer		
٥	or Ita	by Funeral	1 Never Married 2 Married	Armed Forces?		TT	fYes,speci 1 ☐ Yes 2		n, Mexican Specify:	, Puerto F	Rican, etc.)	- 1	Black, White		
215-0036	hours after death with the Maryland tural', or Itams 23a or 28a-f show al Evantinet must be notified at		3X Widowed 4 □ Divorced	If Yes, Give Year or Dates:									Specify: Wh		
<u>រ</u>	"natu	Completed	15. Decedent's Ed (Specify only highest gra	lucation ide completed)		16a. Deced	dent's Usua kind of won DO NOT us	l Occupa k done d	ition <i>Juring</i> most	t of workin	ng	16b. Kin	d of Business/Ir	ndustry	
717	withir ene. than	dmc	Elementary/Secondary (0-12)	College (1-4or 5	5+) [J.S. F						Fede	eral Gov	zernmen	t
0	e filed within 72 h al Hygiene. i other than "natu vant, Ilm Medica	Be C	17. Father's Name (First, Middle, Last)								(First, Middle	, Maiden S	Sumame)		
<u> a</u>	uld be Aenta rked tic ev	To B	Ellison Warner						Pea	arl P	lymess	er			
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Itams 23a or 28a-f show any injury or other traumatic evant, Itam Medical Exact intermet the notified at ance.		19a. Informant's Name/Relationship (*) Robert B. Warner				_					-	Town, State, Zi		
ā,	other other		20a. Method of Disposition		20b. Pla	ace of Dispo metery, crer	sition (Nam	e of her place	9)		ate 1	20c. Loc	ation - City or T	own, State	
Baltimore,	Page nent c ant: If ary or		1 ☐ Burial 2 X Cremation 3 ☐ 1		1	opoli			- 1	Nov. 200	-	Alex	kandria,	Virgi	nia
<u>=</u>	apartn sports sports sy inju		21. Signature of Furieral Service Licer	ISBB		22	. Name and	d Addres	s of Facility	y DeV	ol Fun				
D —	90 = 99		July C.	WU									irg, MD	20877	
ř	Physician /Medical		23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	one cause on each li	_{ne.} Lmonal	Le	er the mode	of dying	g, such as	cardiac oi	r respiratory a	irrest,		Approximate Interval Bety Onset and D	veen
	Examiner			Due to (or as			nsion								
l.		Jer	Sequentially list conditions, if any, reading to inmediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as											
	cuted nd ransit	Examiner	triat initiated events	c. Atrial			on								
Š,	ate be executed oblysician and the burial-transit		resulting in death) Last	Due to (or as		,							Ţ		
8/PO	cate b	dlcal		d. Aspirat	lon i	neumo	nia								
O. Box 6	the death certificate be executed y the attending physician and ched for use as the burial-transit	Physiclan/Med	IFFEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, out <i>co</i> me 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetel	death 3	Ectopic pre Other (spe					2	3d. Date of deliv		'ear
ecords, P.	law requires that the d as been signed by the 2 should be detached	by	Part II. Other significant conditions of Renal Failure	ontributing to death b	ut not resul	Iting in the u	nderlying ca	iuse give	n in Part I.				e contribute to		
S	w req	Completed	Prostate Cance	r							24a. Was	an	24b. Were auto	opsy findings a	available
T,	The la	mo									auto perfo	psy ormed? 2 X No	prior to co death? 1 \(\sum \text{Yes}	mpletion of ca 2□ No	ause of
Vital	an: Trifical	e	25. Was case referred to medical						26. Place	of Death	(Check only		1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	20 140	
	Physician: The lav this certificate has ral director, page 2	To B	examiner? 1 Tyes 2 X No	Hospital: 1 📉 Inpatie	ent 2 🗆 E	R/Outpatier	t 3 DO	A Othe	or: 4 □ Nui	rsing Hon	ne 5 🗆 Resi	dence 6	☐Other (Speci	fy)	
lon of	_ = =		27. Manner of Death 1 XNatural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Inju (Month, Da	y Year)	28b. Time of Injury	M 28	Bc. Injury Work 1 📋 Y	at :? (es 2 □ N		8d. Describe	how injury	occurred		
Division	To the Hospital or Attanding within 24 hours after death. To tha Funaral Diractor: Afte completely filled in by the fune	Certification:	3 Suicide 6 Could not be determined				eet, factory,	office		2	8f. Location (City or To		Number or Rur	al Route Numi	ber,
	te Hospit 24 hour ta Funare Metely fille	edical (29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exam	nysician: To the best niner: On the basis o and manner sta	f examinati	vledge, death on and/or in	occurred a vestigation,	at the tim in my op	e, date and inion, deat	d place, a th occurre	nd due to the d at the time,	cause(s) a date and	and manner as s place, and due t	stated. o the cause(s)	
	To th To th	M	29b. Signature and title of certifier	1 01			,	2	number			29d. Date	signed (Month,	Day, Year)	
1	9+1		- Kathlen	me de	tem			le c	27	3.		Nov	ember 1	, 2004	
	1		30. Name and address of person who					_	, "-	0.1				1 000=	2
			Kathleen McShane 31. Date filed (Month, Day, Year)	32. Registr			Grove	e Koa	ad #2	OT]	KOCKVI.	LIE,	Marylan	a 20850	J
	Sta Registr				ars Signati	19	Sp	all	1						

		1 _ State	partment of Health and Mertificate of Death	ental Hygi	ene
0		Registrar 1. Decedent's Name (First, Middle, Last)	eruncale of Death	2. Date of Death	3. Time of Death
Physi /Med		UTHO WONGUS		Month	27 2004 9:10 P M
Exam	niner	4a. Facility Name (If not institution, give street and number) VA MEDICAL CENTER	4b. City, Town, or Location of Death BALTIMORE		4c. County of Death
Funera	al	5. Social Security Number 6. Sex 7. Age (In yrs. last birtho	ay) If Under 1 Year If Under 24 Hrs.	8. Date of Birth (Month, Day,	9. Birthplace (State or Foreign
Directo	or	2/6-38-9683 1 MM 2 F 63 Yrs Usual Residence of Decedent		March &	15,1941 Maryland
Marylar f show	j.	10a. State 10b. County 10c. City, Town of Dorchester 20			10d. Inside City Limits 1 ☐ Yes 2 ☐ No
5 th the	irec	10e. Street and Number	101. Zip CodeV	10	g. Citizen of What Country?
s 23a	rai	701-Race Street Apt. 40		11 11 11	USA
Baltimore, IMaryland 2.12.13-0030 (by Funeral Director	If Yas Giva	I3. Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto I 1 ☐ Yes 2 ☑ No Specify:	cify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc.
5-UU36 72 hours aff natural; or	ted b	3 Widowed 4 Divorced Year or Dates: 1965	ecedent's Usual Occupation	1	Specify31acK 6b. Kind of Business/Industry
ithin 7	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	ive kind of work done during most of workir e. DO NOT use retired)		
filed w Hygiei kherti			uck Driver 18. Mother's Name	(First, Middle, M	Trucking Company laiden Sumame)
lid be Aental riked o	To Be	· (1.1			Bowens
Maryland d 2 should be file th and Mental Hy ? Is marked othe treumatic event,		19a. Informant's Name/Relationship (Type, Print)	aifing Address (Street and Number or Rura	Route Number,	City or Town, State, Zip Code)
e, R 1 and Health lem 27		Lynette Wongus 80 20a. Method of Disposition 20b. Place of Di	sposition (Name of D	ate 2	oridge MD, 21613
altimore, rmit. Pages 1 ar partment of Hea portent: If Item y injury or other		1 Begrial 2 □ Cremation 3 □ Removal from State '4 □ Donation 5 □ Other (Specify) Vetero	organizations of other place) NS CEMETERY 11/8	104	HURLOCK, MD
Dalti permit Departm Importe any inju	ouce.	21. Signature of Funeral Service Licensee	22. Name and Address of Facility	Home, F.	A. bridge,MD.21613
	a	23a. Patr. Enter the disease, or complications that caused the death. Do not	5 10 Washington S	+, Cam	bridge, MD. 21613
Physicia		shock, or heart failure. List only one cause on each line.	enter the mode of dying, sacr as caldiac o	respiratory arre	Interval Between Onset and Death
/Medica	al	disease or condition resulting in death) a. SEPS(Due to (or as a consequence of):			
Examine		Sequentially list conditions, b. Due to for as a consequence of	ENOCARCINOMA OF	LUNGS	
uted d ansit	Examiner	Sequentially list conditions, I ally ist conditions, I all list conditions, I	A OF LUNGS		
st ou, ate be executed sysician and he burial-transit			TA ST TOP	-	
oo/o	edical				
BOX 08 / 0U, eath certificate be ex attending physician for use as the burial	n/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy			23d. Date of delivery
THECOIDS, P.O. BOX OS The law requires that the death certifica ate has been signed by the attending phage 2 should be detached for use as the	Physician/M	1 Live birth 2 Fetal death in the past 12 months? 1 Yes 2 No 9 Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		Month Day Year
IS, F.C. I res that the de signed by the a	Phy	Part II. Other significant conditions contributing to death but not resulting in the	e underlying cause given in Part I.	23e. Did toba	acco use contribute to the cause of death?
w requires been sign	ed by			Yes	s 2 No 3 Probably 4 Unknown
he law requires t he has been signe age 2 should be o	Completed			24a. Was an autopsy	prior to completion of cause of
VICAL INEC sicien: The law certificate has t lirector, page 2 s					No 1 Yes 2 No
Of VICAL Physicien: T rthis certificat ral director, pa	. Be	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 FR/Outpa	26. Place of Death		nce 6 Other (Specify)
on or ding Phys h. After this funeral di	Ť.		e of 28c. Injury at 2	8d. Describe how	
JVISION or Attending after death. Director: After	Cati	2 Accident investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm	M 1 Yes 2 No	PRf Location (Str	eet and Number or Rural Route Number,
DIVISION STATEMENT STATEME	Certification:	4 Homicide determined building, etc. (Specify)	Silest, lactory, office	City or Town,	State)
LIVISION OF VITAL HO To the Hospital or Attending Physicien: The within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	Polical		eath occurred at the time, date and place, a r investigation, in my opinion, death occurre	and due to the car ad at the time, da	use(s) and manner as stated. te and place, and due to the cause(s)
To the within 2.	N		29c License number	29	d. Date signed (Month, Day, Year)
		1 pm procedure MD	1513 AFU	SAFABL	0127104
		30. Name and address of person who completed cause of death (Item 23a) (Ty	POPER STREET, BA	I TIMON :	(MD 21717-
	State	31. Date filed (Month, Day, Year) 32. Register's Signature	- Mer sheep / Du	אועייון	- I'V HUT

DHMH 17 Rev 1/2001

ORIGINAL

			1 - For State Registrar	State of Maryla	and / Depa		Health and M	lental Hyg	•		20005
			Decedent's Name (First, Middle, Last	t)		imouto or	Dodin	2. Date of Dea	th		3. Time of Death
	Physic /Medi		Helen Ruth Webs	ter				Oct. 2	29, Day 2004	Year •	Midnight™
	Exami		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, o	or Location of Death		4c. County		
			Mallard Bay Nur			Cambri				chest	
	Funeral Director		220-12-2203	7. Age (In y	rrs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day Oct. 4,	1921	9. Birthpl Coun, Mary.	ace (State or Foreign try) Land
	land		Usual Residence of Decedent 10a. State 10b. County	10c.	City, Town or Lo	ocation				10	Od. Inside City Limits
\Im	Mary f sh	to	Maryland Dorches	ter		Cambridge					1 Wes 2 No
\mathcal{I}	or 28s	irec	10e. Street and Number			10f. Zip Code		1	0g. Citizen of V	Vhat Coun	try?
2	death with the Maryland rns 23a or 28a-f show rnst be netified at	ra D	1509 Race Street	Extended		21	613			USA	
98	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Modical Examiliar in the Item Items and once.	Completed by Funeral Director	Marital Status Never Married 2 Married Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		Was Decedent of Hif Yes, specify Cub	Hispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race Blace Specify	e - America k, White, a ': Whit	etc.
21215-0036	2 hou atura	led	15. Decedent's Ed	ucation	16a. Dece	dent's Usual Occup	pation		16b. Kind of Bu		
215	within 7; ene. than "n	ple	(Specify only highest gra	de completed) College (1-4or 5+)	(Give	kind of work done DO NOT use retire	oation during most of work d)	ing			•
	2 should be filed withir and Mental Hygiene. is marked other than surnatic event, Ita M.	Con	12		Shi	pping Cl	1				Manufacture
pu	be fill tal Hi d oth	Be	17. Father's Name (First, Middle, Last)				18. Mother's Name	-		*	
ryla	should ind Men s marke umatic	P	Rev. Charles Can		10h Maili	Address (Ct.)		E. (maid			
Maryland	d 2 st th and 7 is r traun		William L. Jones/	•			and Number or Run				
	1 an Heal tem 2		20a. Method of Disposition		b. Place of Dispo	sition (Name of	reet Exte		20c. Location -		
ē	ages ant of it: If if		1 ☐ Burial 2 ☑ Cremation 3 ☐ `4 ☐ Donation 5 ☐ Other (Specify	Removal from State	-	natory or other pla	center10/.	30 /2004	Combaid	122 N	MD.
Baltimore,	permit. Pages 1 and Department of Health Important: If item 27 any injury or other tr once.		21. Signature of Funeral Service Licen	see /	22	2. Name and Addre	ss of Facility				YID
ñ	Departr Departr Imports any inju		Carle of There	at France	vell	Curren-B	romwell Fi St., Cam	meral H	ome 2161	<u>۸</u> .	
	1000		2 a. Part I Inter the dis ase, or comp shock, or heart failure. List only		eath. Do not ent	er the mode of dyi	ng, such as cardiac	or respiratory arr	est,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Arterio							Onset and Death
	/Medical		resulting in death)	Due to (or as a con:		-					
т	Examiner		Sequentially list conditions	b							
	70 ##	Examiner	Sequentially list conditions, if any, leading to immediate cause. Early Underlying Cause (Disease or injury that initiated events	Due to (or as a con-	sequence of):						
	ecute and I-trans	каш	that initiated events resulting in death) Last	c. Due to (or as a cons	sequence of):						
760,	icate be executed physician and s the burial-transit	cal E		545 (5) 43 4 (5)1.	304061106 01).						
687	phys the	dic		d						-	
Box (eath certificat attending phy I for use as the	/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pre					23d. Date	e of delive	v
O.	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Medi	in the past 12 months? 1 Yes 2 No 9 Unknown	1 □ Live birth 2 □ F 4 □ Pregnant at time of 9 □ Unknown		Ectopic pregnanc Other (specify)	у		Mor		Day Year
Δ.	res that igned b be deta	by Pł	Part II. Other significant conditions of	ontributing to death but not	resulting in the u	nderlying cause giv	ven in Part I.	23e. Did tob	acco use contr	ibute to the	a cause of death?
rds	w require been sig should b	ed b				·		1 □ Ye	s 2 No	3 🗌 Proba	ıbiy 4 ⊠Ünknown
Records,	aw re	Completed						24a. Was a		Vere autop	sy findings available
Ä	The i	E O						autops perforr	ned?	leath?	pletion of cause of
Vital	sician: The law certificate has b irector, page 2 s	Be C	25. Was case referred to medical examiner?				26. Place of Death				
of V	Physician: this certific ral director,	Jo E	1 Yes 2 No	Hospital: 1 ☐ Inpatient 2	ER/Outpatier	nt 3 DOA Ott	ner: 4 Avursing Ho	me 5 🗆 Reside	ence 6 Othe	er (Specify,)
0 4			27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year	28b. Time of Injury	Wo	ry at rk?	28d. Describe ho	w injury occurre	ed	
sio	death. ctor: A y the fu	cati	2 Accident investigation 3 Suicide 6 Could not be				Yes 2 □ No				
Division	or Attendate death after death Director:	Certification;	4 Homicide determined	28e. Place of Injury - A building, etc. (Sp	it home, farm, str ecify)	reet, factory, office		28f. Location (St. City or Town	reet and Numbe 1, State)	er or Rural	Route Number,
	To the Hospital or Attending within 24 hours after death. To the Funeral Director; Attencompletely filled in by the fune		29a. Certifier 1 Certifying Ph	unicians. To the heat of my	kaaniladaa daati						
	To the Hospital within 24 hours a To the Funeral completely filled	Medicai	(Check only 2 Medical Exam	ysician: To the best of my iner: On the basis of exam and manner stated.	ination and/or in	vestigation, in my o	ppinion, death occurr	ed at the time, da	ate and place, a	ind due to	the cause(s)
	vithin To the	Me	29b. Signature and title of certifier	IN GLA		29c. Licens	se number	2	9d. Date signed	(Month, E	Day, Year)
	- > - 0		1 wery	MY MD		DU	7924	/	10.29	-04	
			30. Name and address of person who	complete cause of death (Item 23a) (Type,						
_			NOMAN THANK	NY 300 AZ	RORA	STREET	CAMBR	1066	00	2/6	13
	St	ate	31. Date filed (Month, Day, Year)	32. Registra & Si	gnature	1.1					

			1- State of Maryland / Department	artment of Health and M rtificate of Death	ental Hygier	711111	36666
			Decedent's Name (First, Middle, Last)		2. Date of Death		3. Time of Death
	Physici /Medic		June Aura Walker	_		Day Year 2004	7:15 P M
	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	
			Villa Rosa Nursing Home	Mitchellville		Prince Ge	orge's
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	9 Date of Righ	O Dieth	-lane /Class ou Foreign
	Director		578 12 4298 1 M 2 XX 87 Yrs.	World Suys Floure Will.	June 30,	1917 Wasi	ntry) nington DC
	pu .		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Lo	ocation			10d. Inside City Limits
	sho	ō					1 □ Yes 2 □ No
	28a-1	Director	Delaware Sussex Selby v	1 1 L C	100	Citizen of What Cou	
	with la or	ă	37 Bay View West	19975		nited Stat	,
	ns 23	Funeral				14. Race - Ameri	
(0	r Itar	Fun	Armed Forces? I	Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto I	Rican, etc.)	Black, White,	etc.
8	be filed within 72 hours after death with the Maryland ital Hygiene. id other than "natural", or Itams 23a or 28a-f show adont. I're Madical Exa. ilirar i saat be mailind at	by	An If Yes, Give AX Year or Dates:	1 □ Yes 2 □ No Specify:		Specify: Wi	nite
2-0	72 ho	Completed	15. Decedent's Education 16a. Deced (Specify only highest grade completed) (Give	dent's Usual Occupation kind of work done during most of working	16b.	Kind of Business/In	dustry
2	ithin le.	nple.	Elementary/Secondary (0-12) College (1-4or 5+)	DO NOT use retired)			
2	e filed within al Hygiene. I other then vent, Ire M.			Processing Superv		R.S.	-
ano	ould be fi Mental H arked ot atic avar	Be	17. Father's Name (First, Middle, Last) Ralph E. Waler		(First, Middle, Maid	en Sumame)	
ž	2 should be and Mental la marked of aumatic av	은		ng Address (Street and Number or Rura		y or Tours State 7in	Code
Maryland 21215-0036	d 2 s th an th an traus			Bay View West, Sell			Code)
ē,	pernit. Pages 1 and 2 should Deportment of Health and Mer Important: If item 27 la marke any njury or other traumatic 2006.	3	20a Method of Disposition 20b. Place of Dispo	sition (Name of	1	Location - City or To	own, State
Baltimore,	ages ant of it: If i		I Buriai AMCremation 3 Hemoval from State	matory or other place)	61		
葟	ortan		TIEC CLEI	matory Nov 1. 2004 2. Name and Address of Facility Lee	Funanci I	inton, Ma	ryland
ä	Depoil Impount any conce		1 King D. 1140 1284	Alexandria Ferry I	runerar r Rd Clinto	nome, inc c	nd 20735
1	*,		23a. Part1. Enter the disease, or complications that caused the death. Do not ent shock, or heart failure. List only one cause on each line.	•		on, naryre	Approximate Interval Between
W	Pnysician		Immediate Cause (Final	silver I Ha	40). 0		Onset and Death
	/Medical		disease or condition resulting in death) a. Due to (or as a consequence of):	1012 10	in ore		occa fr
	Examiner		Securetially list anaditions h De Mext A. A	- by hours type			yrs
	P #	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	0 7			1
	and trans	Examiner	that initiated events c.				
60,	death certificate be executed e attending physician and de for use as the burial-transit		Due to (or as a consequence of):				
8760	cate be er physician the buria	dlcal	d				
9 X	eath certific attending p for use as f	lan/Me	IF FEMALE: 23c. If yes, outcome of pregnancy			G2d Date of dollar	
Вох	atten for u	clan	in the past 12 months?	Ectopic pregnancy Other (specify)		23d. Date of delive Month	Day Year
o.	the y th iche	Physic	1 Uyes 2 No 9 Unknown	, , , , , , , , , , , , , , , , , , , ,			
٣.	pa es	by Pł	Part II. Other significant conditions contributing to death but not resulting in the un	nderlying cause given in Part I.	23e. Did tobacc	o use contribute to t	he cause of death?
rds	w requires been signi should be				1 🗆 Yes	2 □ No 3 □ Prob	pably 4 Onknown
Records,	≥ 0 0	ompleted			24a. Was an	24b. Were auto	psy findings available
æ	t: The lavicate has	Ho			autopsy performed?	death?	mpletion of cause of
Vital		Be C	25. Was case referred to medical	26. Place of Death		10 10 100	
f V	y sign	To	examiner? 1 Yes	nt 3 DOA Other: XX Nursing Hon	ne 5 🗆 Residence	6 ☐Other (Specif	y)
n of	ng Ph fter th meral		27. Manner of Death Natural 5 Pending 28a. Date of Injury (Month, Day Year) 28b. Time of Injury	f 28c. Injury at 2 Work?	8d. Describe how in	jury occurred	
Sio	Attanding r death. actor: After	cati	2 Accident Investigation	M 1 Yes 2 No			
Division	or At	Certification	4 Homicide determined 28e. Place of Injury - At home, farm, str. building, etc. (Specify)	eet, factory, office 2	8f. Location (Street City or Town, Sta		il Route Number,
	ne Hospital or Attanding Ph n 24 hours atter death. ne Funaral Diractor: Atter th bletely filled in by the funeral		29a. Certifier Certifying Physician: To the best of my knowledge, death	<u> </u>		(-)	
	24 hc 24 hc Fun etely	dical	29a. Certifier (Check only one) One) One) One) One) One) One) One) One) One) One) One) One) One) One) One) One) One) One) One) One) One) One) One) One) One) One) One) One) One) One) One) One) One) One) One) One) One) One) One) One) One) One) One) One) One) One) One) One) One) One) One) One) One) One) One) One) One) One) One) One) One) One) One) One) One) One) One) One) One) One) One) One) One) One) One) One) One) One)	vestigation, in my opinion, death occurre	and due to the cause and at the time, date a	(s) and manner as s and place, and due to	tated. the cause(s)
	To the Hospital or within 24 hours afte To the Funaral Dir completely filled in	Med	29b. Signature and title of certifier	29c. License number	29d. E	Date signed (Month,	Day, Year)
)	- S - 0		* MI Mo	D37761	11	-1-20	04
(30. Name and address of person who completed cause of death (Item 23a) (Type,	Print)	1 (-
	815		Richard I Foldman M.D. 0500 4	olis Road, #A-4, La	anh = 3m ²	20706	
	Sta				annam, MD		
	Registr	ar	31. Date filed (Month, Bay, Year) 32. Figistrar's Signature	med .			

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Peter Joseph Watters October 30 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Medical Center Annapolis Anne Arundel If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth (Month, Day, Year) Months NOXM 2□F 197-28-1097 Yrs. Director 70 1934 Pennsylvania Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c, City, Town or Location 10d. Inside City Limits Itam 27 is marked other then "natural", or Itams 23a or 28a-f show other traumatic event, the Mudical Examinar must be notified at Director Maryland Anne Arundel Annapolis 1 ☐ Yes 25No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 2609 Ogleton Road 21403 U.S.A. by Funeral 12. Was Decedent Ever in U.S. Amed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after one of Health and Mental Hyglene. Int: If Itam 27 Is marked other then "natural", or Ite 1 Never Married 2 Married XYes 2 □ No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify If Yes, Give Year or Dates: White Specify: 3 Widowed 4 Divorced 1954-56 Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Attorney U.S. Government 4 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Watters Elizabeth Garrity 0 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Tonia Watters/wife 2609 Ogleton Road Annapolis, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removal from State permit. Page Department o Important; If any injury or once. injury or Baltimore Crematory 11/1/2004 Baltimore, MD ' 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility John M. Taylor Funeral Home 147 Duke of Gloucester St. Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death nmediate Cause (Final **Physician** MONE XIMA)an disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Usease or injury that initiated events resulting in death) Last Due to (or as a consequence of): ed by the attending physician and detached for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4☐ Pregnant at time of death 5 ☐ Other (specify) 9 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobaçco use contribute to the cause of death? à should be 1 2 Yes 2 □ No 3 □ Probably 4 □ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an certificate has 2 No 2 No 1 Yes 1 Yes Hospital or Attanding Physician: 24 hours after death. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 2 No Hospital: Other: 1 Inpatient 1 🗌 Yes 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this filled in by the funeral 27. Manuer of Death 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Certification: After 5 Pending investigation Natural 1 ☐ Yes 2 ☐ No 2 Accident Diractor; 6 ☐ Could not be 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital within 24 hours a To the Funaral Completely filled in 'Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of centifie 29d. Date signed (Month, Day, Year) 2004 M death (Item 23a) (Type, Print) (70 31. Date filed (Month, D. Year) gistrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2 U 0 4 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth Month Nov 9, **Phyllis** Zembower 2004 Shirley 3:50AM 4a Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Cumberland Nursing Center Allegany Cumberland If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Months Hours 1 M 2 ByF Yrs. 217-10-1420 85 Jan 4, 1919 MD Usual Residence of Decedent 10a. State 10c. City, Town or Locetion 10d. Inside City Limits Allegany MD Cumberland 1 Ves 2 No 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 221 Humbird Street 21502 USA Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 1 Yes 2 No If Yes, Give X Yeer or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: 3 Nidowed 4 □ Divorced white 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Sales Clerk Cumberland Cloak 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Virgil McElfish Florence Mae (Miller) McElfish 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JoAnn Jenkins daughter 222 Humbird Street Cumberland MD 21502 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Dete 20c. Location - City or Town, State 1 D urial 2 □ Cremation 3 □ Removal from State Fellowship Cemetery 11/12/2004 Centerville 4 ☐ Donetion 5 ☐ Other (Specify) PA 22. Name and Address of Facility Scarpelli Funeral Home, PA 21. Signature of Funeral Service Licensee 108 Virginia Avenue: Cumberland, MD 21502 23a. Part 1. Enter the disease, or complications that daused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Ceuse (Final disease or condition resulting in death) Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Diseese or injury that intieted events resulting in death) Last Due to (or es e consequence of) Due to (or as e consequence of): 23b. Did tobacco use contribute to the cause of death? 2 ×40 3 Probably 4 Unknown il for ! 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) Hospital: Other: 4 ursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of 28d. Describe how injury occurred 28e. Date of Injury (Month, Day Year)

Physician /Medical Examiner Physician/Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

items 23s or 28s-f show ner must be notified at

Funeral Director

Be Completed by

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural; or items 23s or 28s-f show

Baltimore, Maryland 21215-0020

or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, within 24 hours after death. To the Funeral Director: After this certificeta has been signed by the a complataly filled in by tha funeral director, paga 2 should be detached f

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Be Completed

Medical Certification: To

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 25. Was case referred to medical examiner? 1 Yes 2 No 28c. Injury et Work? 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify)

27. Manner of Death 1 Naturel 2 Accident 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifie

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Cumberland Adrison

State Registrar

31. Date filed (Month, Day, Year)

NOV 1 8 2004

32. Registrar's Signeture,

		1	For State Registrar	State of Maryland / Department of Health and M Certificate of Death		e2e0 0 L	36669			
	sicia	n	1. Decedent's Name (First, Middle, Last)	Kins	2. Date of Death Month November	Day Year	3. Time of Death ScotAM			
		r	5. Social Security Number 6. Sex 2 (2-34-469)	race Catan Maror Balfimore	8. Date of Birth (Month, Day,	4c. County of Death A Year) 9. Birthp County FEN	place (State or Foreign ntry) NSY/Van Ia			
Maryland			Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Location Baltimore			10d. Inside City Limits 1 XYes 2 ☐ No			
h with the		5	10e. Street and Number 5/1/0/Baltamore	National Pike 21229	10	g. Citizen of What Cour USA	ntry?			
d 21215-0036 filed within 72 hours after death with the Maryland Hygiene "haturel", or Items 23e or 28e-1 ehow hit the Marilled Farmer to Refine and		by rur	11. Marital Status 1 Never Married 2 Marned 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1	ecify Yes or No- Rican, etc.)	14. Race - Americ Black, White, Specify: Black	can Indian, etc.			
21215-0036 od within 72 hours af gjiene. er than "naturel", or		Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	cation e completed) College (1-4or 5+) 16a. Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired) College (1-4or 5+)	ing	6b. Kind of Business/In	dustry (V) 9			
Maryland 21 d 2 should be filed w tth and Mental Hygien 27 le marked other th		o ge C	17. Father's Name (First, Middle, Last) Ben (amin 19a. Inform s Name/Relationship (Ty)	J. Macer Elsi	e (First, Middle, Mi	Bermai	n Code)			
Ore, jes 1 an of Heal if Item 2			NS Pobin Ha 20a. Method of Disposition 1 MBurial 2 Cremation 3 R 4 Donation 5 Other (Specify)	YWOOd 7926 Dunbill VII	lage#2	15 D. H.	Md, 21244			
Baltim permit. Peg Department Importent:	ODC6		21. Signature of Funeral Service License 23a. Perri Enter the di Pase, or com 3ii	22. Name and Address + Facility Joseph Links 2222 W. North Ave	Funera		Approximate			
Physici /Medio Examin	ai		23a. Perri Enter the di Aase, or combination or heart failure. List only on immediate Cause (Final disease or condition resulting in death)	Due to (or as a consequence of):	or toophatory arrow		Interval Between Onset and Death			
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O. BOX (In death certification of the aftending the death of the aftending the death of the age of		Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown	3c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify)		23d. Date of delive	ery Day Year			
COTGS, P.(w requires that the been signed by		D O	Part II. Other significant conditions con	ntributing to death but not resulting in the underlying cause given in Part I.		acco use contribute to the	4.4			
	1	Completed				ed? prior to condeath? Mo 1 ☐ Yes	ppsy findings available impletion of cause of 22 No			
		10 De	1 □ res 2pa no	ospital: 1 ☐ Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA Other: 4 ☑ Nursing Ho		ice 6 □Other (Specif	y)			
Division of Vita or Attending Physician: after death. Director: After this certification by the fundral director.	:	cation	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation	28a. Date of Injury (Month, Day Year) 28b. Time of lnjury Mork? M 1 ☐ Yes 2 ☐ No	28d. Describe how	r injury occurred				
Division To the Hospital or Attention within 24 hours after dealt To the Funeral Director: To che Funeral Director:		Certification:	3 Suicide 6 Could not be determined	building, etc. (Specify)	City or Town,					
the Hosp in 24 hou the Fune		edical	(Check only 2 Medical Examinate)	sician: To the best of my knowledge, death occurred at the time, date and place, ner: On the basis of examination and/or investigation, in my opinion, death occurr and manner stated.	ed at the time, dat	e and place, and due to	o the cause(s)			
To T To 1		Σ	29b. Signature and title of certifier	andy Physician D536	42 N	d. Date signed (Month, 6 Vembor	122004			
	5		30 Name and address of person who co	mpleted caus of death (Item 23a) (Type, Print) 5601 LOCK Pavon Blud 30	3 Bul	timoro a	2/239			
Rec	Stat	-	31. Date filed (Month, Day, Year) NOV 1 9 2004	32 Registrar's Signature						

			1 - For State Registrar	State of Maryland / Department of Health and Ment Certificate of Death	Reg. No. 2004 36670
Ç.	Physici /Medio		1. Decedent's Name (First, Middle, Last, Bennie	4	ate of Death lonth Day Year 3. Time of Death Over 10, 2004 7,15 m
	Examir Funeral Director	er	4a. Facility Name (If not institution, give 90	Son Ave Baltimore 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8 Da	ate of Birth 9. Birthplace (State or Foreign Country)
Baitimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: It flem 21s marked other than "natural; or Items 23s or 28s-1 show any injury or other traumatic event, the Medical Evaluation must be notified at once.	To Be Completed by Funeral Director	Natylana No. County Natylana No. Street and Number 906 Edmor	(Give kind of work done during most of working life. Do NoT use retired) 18. Mother's Name (First, Anne Pout 19b. Mailing Address (Street and Number or Rural Route 190 Eamon State 20b. Place of Disposition (Name of cemetery, crematory or other place) 19. Place of Disposition (Name of cemetery, crematory or other place)	Specify: Black 16b. Kind of Business/Industry Private Companies Middle, Maiden Surname) Corr Number, City or Town, State, Zip Code) Ve. Butto, Md. 21223 20c. Location - City or Town, State
	Physician physician and physician and physician and physician and physician street transit	edical Examiner	23a. Pertyl Enter the disease, or complished, or heart fallyre. List only or Immediate Cause (Final disease or condition resulting in death) Esquentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that infitated events resulting in death) Last	Due to (or as a consequence of): Due to (or as a consequence of):	Interval Between
	the death certific y the attending p iched for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	ic. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown	23d. Date of delivery Month Day Year
L (2)	quires that n signed b uld be deta	þ	Part II. Other significant conditions con	ributing to death but not resulting in the underlying cause given in Part I. 23	le. Did tobacco use contribute to the cause of death? 1 Yes 2 Volume 1 Probably 4 Unknown
vital necolus,	in: The law recilicate has bee	e Completed	CONGESTIVE	HEART FALLRO 24 ECDOMS, HYPERTEHSING HEART PASENT IC	a. Was an autopsy performed? Yes 2 No 1 24b. Were autopsy findings available prior to completion of cause of death?
	To the Hospital or Attending Physician: The law requires that the death certifult 24 hours after death. Within 24 hours after death. To the Fundrail Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use a	Certification: To B	examiner? 1 Yes 2 No He 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	28d. Delete of Injury at Work? (Month, Day Year) 28d. Inme of 28c. Injury at Work? M 1 Yes 2 No 28e. Place of Injury - At home, farm, street factory office.	escribe how injury occurred
5	dospital or 4 hours afte uneral Dir aly filled in	edical Cert	29a. Certifying Phys	building, etc. (Specify) Cian: To the best of my knowledge, death occurred at the time, date and place, and due etc. On the basis of examination and/or investigation, in my opinion, death occurred at the	y or Town, State)
	To the within 2: To the ! complete	Medi	29b. Signature and title of certifier	D14900	29d. Date signed (Month, Day, Year)
	Stat Registra	-	30. Name and Id ress of person who cor ALGELTA 31. Date filed (Month, Day, Year) NOV 1 9 2004	TO PACE, M-D /72/ PF LEWSYLV & LED 32. Registrar's Signature Server 4. Annual / PERSYLV & LED 32. Registrar's Signature	IN DUE BRITIMORE, NO 21217

ORIGINAL

			For State Registrar	State of	Maryland	-	artment of F		and Mental H	lygiene Reg.	1001	36671	
	Physici /Medic		Decedent's Name (First, Middle MARY ANN	e, Last) BRILHART					2. Date of Month NOVEM		ĭ8 2004	3. Time of Death 5:00 PM	
	Examin		4a. Facility Name (If not institution 809 LUCKY RD.				4b. City, Town, of SEVERN If Under 1 Year	or Location o		A	. County of Death	DEL	
	Funeral Director		5. Social Security Number 180-24-0910 Usual Residence of Decedent	6. Sex X 1 M ZDF	7. Age (In yrs. Ia 72	Yrs.	Months Days	Hours	Min. OCTOBI	ER 19	, 1932 ^{co}	place (State or Foreign Intry) PENNSYLVANIA	
	the Marylan 7 28e-f ehow	irector	10a. State 10b. County MARYLAND ANNE 10e. Street and Number	ARUNDEL		, Town or Lo	10f. Zip Code			10g. Ci	itizen of What Cou	10d. Inside City Limits 1 Tyes ANO intry?	
36	d within 72 hours after death with the Maryland Jiene. r than "natural", or Hems 23a or 28e-f ehow The Madical Examiner must be motified at	by Funeral Director	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:					an, Mexican	gin? (Specify Yes or , Puerto Rican, etc.)	No-	NITED STATES 14. Race - American Indian, Black, White, etc. Specify: WHITE		
21215-0036	d within giene. rr than "	Completed		t's Education st grade completed) College (1	-4or 5+)	(Give	lent's Usual Occup kind of work done OO NOT use retire [AKER	durina most	af working	Kind of Business/Ir	ndustry		
Maryland	should be filed ind Mental Hygi marked other umatic event, II	To Be (17. Father's Name (First, Middle, JAMES MARSHAL)	L BALDWIN				ESTI	r's Name (First, Mide ELLE M. CO	LBURI	N		
altimore, Mary	Health ar Health ar tem 27 Is		19a. Informant's Name/Relations ROBERT W. BRIL 20a. Method of Disposition 1X Byrial 2 □ Cremation 4 □ Denation 5 □ Other (5	HART - HUS	20b. Place	809 L ace of Dispo		D, SEV	r or Rural Route Nur VERN, MD 2 OVEMBER 2, 2004	21144 20c. L	ocation - City or T	own, State	
Balti	permit. Pages Department of Importent: If i any Injury or o		21. Signat to of Fund al Service	~~			RKTER ARU I CRAIN				BURNIE, N		
	Physician /Medical Examiner		23a. Part1. Enter the disease, o shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)	a	aused the death ach line.	die	Luny		cardiac or respiratory	y arrest,		Approximate Interval Between Onset and Death	
8760,	icate be executed physician and sthe burial-transit	edicai Examiner	Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that indiated events resulting in death) Last	С	or as a consequ								
.O. Box 6	the death certify the attending iched for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 ☐ Live b	come of pregnar irth 2 Tetal ant at time of de own	death 3	Ectopic pregnanc Other (specify)	у			23d. Date of deliv Month	ery Day Year	
rds, P	uires tha signed d be de	by	Part II. Other significant conditi	ons contributing to de	eath but not resu	lting in the ur	nderlying cause gr	ven in Part I.		id tobacco		the cause of death?	
Vital Records,	The law ate has b page 2 sl	Completed								itopsy irformed?	prior to co	opsy findings available impletion of cause of	
Division of Vita	Attending Physicien: 1 r death. r death. ector: After this certifica by the funeral director, p	ertification: To Be	3 Suicide 6 Could	Hospital: 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	of Injury h, Day Year)	ER/Outpatien 28b. Time of Injury	28c. Injui	ner: 4 ⊡ Nur ryat		esidence pe how inju			
Div	urs afte	O	4 Homicide determ	buildir			eet, factory, office	me, date and	City or	Town, State	θ)		
	To the Hosp within 24 ho To the Fund completely f	Medicai		Exeminer: On the ba and mann	asis of examinati			opinion, deat	th occurred at the tim	e, date an		o the cause(s)	
1)		30. Name and address of person	who completed caus	e of death (Item	23а) (Туре,	Print)		43	05	11/19/	21775	
	Sta		31. Date filed (Month, Day, Year,	32. H	egistrar's Signati	ure Li	L.	1 1 m	34 LTIM	0140	, My,		
	Registr	aı	NOV 1 9 2	.004		N	sporks						

			1- For State of Maryland / Department of Certificate of Certificat	f Health and Moof Death		2004	36672
	Physic /Med	ical	1. Decedent's Name (First, Middle, Last) Bertha E. Brown 4a. Facility Name (If not institution, give street and number) 4b. City. Town		2. Date of Death	Day Year 16, 2004	3. Time of Death 12:01 A M
	Exami Funeral Director	ř	7 1 0 1 1 1 1 1	n, or Location of Death Ltimone Bar If Under 24 Hrs. Bys Hours Min.	8. Date of Birth (Month, Day, Y April 4,	4c. County of Death N/A 9. Birth County 1915 Penn	place (State or Foreign
	aryland 21215-0036 should be filed within 72 hours after death with the Maryland nd Mental Hygiene. marked other than "naturel", or items 23a or 28a-1 show unatic event, the Medical Examinatine reciditied at	erai Director	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location Maryland Anne Arundel 10e. Street and Number 10f. Zip Code 200 Sweetser Road 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent	de 21090	10g		10d Inside City Limits 1 □ Yes 2 □ No intry?
	Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or Items 23a or 28a-1 show any injury or other traumatic event, the Medical Examination and once.	Completed by Funeral	Amed Forces? I Never Married 2 Married 1 Yes, specify C I Yes, Specify C I Yes, Specify C I Yes, Specify C I Yes, Specify C I Yes, Specify C I Yes, Specify C I Yes, Specify C I Yes, Specify C I Yes, Specify C	cupation ne during most of workii tired)	100	b. Kind of Business/In	otc. hite odustry
ms	faryland 2 2 should be filed 5 and Mental Hygi 7 is marked other raumatic event, 1	To Be Co	17. Father's Name (First, Middle, Last) John W. Matter 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Stre	18. Mother's Name Minnie. Beet and Number or Rura		Lcup ity or Town, State, Zip	
BEKHLA BROWN	Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours alt Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Epart once.		Richard E. Brown (Son) 200 Sweetse 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Add	nolace) TU 11/22 dress of Facility Sch	ate 200 1/04 yo himunek F	Location - City or To Ork, PA Uneral Hon	
m B	bhysician and Examiner streams to be invarient and streams to be bright	Examiner	23a. Part1. Enter the bisease, or complications that caused the death. Do not enter the mode of described by the art failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):	Luir Rd., Bo	r respiratory arrest,	MU 21236	Approximate Interval Between Onset and Death
4 13:01 4	P.O. Box (hat the death certion by the attending before the detached for use a	y Physician/Medical	JF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 9 Unknown		23a Did tohaco	23d. Date of deliver Month	Ďay Year
11/11/0		e Completed by			1 Yes 24a. Was an autopsy performed? 1 Yes 2 X	24b. Were autop	ably 4 Unknown ssy findings available interior of cause of
		ertification; To Be	1 X Natural 5 Pending (Month, Day Year) Injury Wo	Yes 2□No		6 Other (Specify)	Hospice
	Division To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Medical Certif	4 Homicide determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the transfer one) 1 Medical Examiner: On the basis of examination and/or investigation, in my and manner stated.	<u> </u>	City or Town, Sta		
	J A)	Jim Hollo MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)		(om	ate signed (Month, Di	, ,
	Stat Registra	. 2	Tim folk MD 620 Boulton Street 31. Date filed (Month, Day, Year) NOV 1 9 2004 Separate Signary Signary Separate Signary	Bel Air MI	71014		

			For State Registrar		State of Ma	aryland /		artment of F				ienę		366	73
	Physici	an	Decedent's Name	(First, Middle,		D				2. 1	Date of Deat Month	th Day	Year Job	3. Time of 0	
	/Medic Examin Funeral Director	er	4a. Facility Name (If A Peninsula 5. Social Security Nu 213 32	Regio		. 4	kr	4b. City, Town, o SALIS bur If Under 1 Year Months Days			Date of Birth (Month, Day,	4c. (County of Deat	h	Foreign
	D		Usual Residence of I	Decedent 10b. County		10c. City, To	own or Lo	ecation						10d. Inside City	
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	th with the 23a or 28a at be noti	Funeral Director	10e. Street and Num		rive			10f. Zip Code 218	11		1	_	en of What Co	untry?	
980	be filed within 72 hours after death with the Maryland lal Hygiene. id other than "natural", or Itams 23a or 28a-f show event, I're Medical Evartinar resal by notified at	by	11. Marital Status 1 Never Marrie 3 Widowed 4		12. Was Decedent Armed Forces? d 1 Yes 2 14 Yes, Give Year or Dates:			Was Decedent of Hif Yes, specify Cuba 1 ☐ Yes 2 No	an, Mexica	n, Puerto Ric	y Yes or No- an, etc.)		4. Race - Ame Black, White Specify: Wh		
21215-0036	within 72 ho ene. than "natur he Medical	Completed		<u> </u>	Education grade completed) College (1-4or		(Give life.	dent's Usual Occup kind of work done DO NOT use retired nemaker	ation during mos d)	st of working			nd of Business/	Industry	
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Maryland	ges 1 and 2 should it of Health and Men if item 27 is merke or other traumatic	T ₀	19a. Informant's Nar Thomas		p (Type, Print) / Husband			ng Address (Street rdsnest					Town, State, 2 yland 2		
Baltimore,	l and lealt im 2 thar		20a. Method of Dispo 1 XBurial 2 ☐ 1 4 ☐ Donation	Cremation :	3 □Removal from State	ceme	itery, cre	osition (Name of matory or other place Veteran		Date 11/22,			cation - City or wnsvil	Town, State Le, Mary	/land
Balt	permit. Pages. Department of the Important: If ite any injury or of once.		21. Signature of Fun	· · h	Znamia	ush	4	2. Name and Addre	nie H	ighway	Ba1	timo		e, P.A. Tyland 2	
	Physician /Medical Examiner		23a. Part1. Enter the shock, or head immediate Cause (f disease or condition resulting in death)	Final	a. Due to (or as	the death. In the second of th	tro	ter the mode of dyir	ng, such as	s cardiac or re	espiratory arr	est,		Approximate Interval Betw Onset and D	eath
8760,	be executed ician and burial-transit	al Examiner	Sequentially list confi any, leading to imicause. Enter Under Cause (Disease or that initiated events resulting in death) L		ه ده	a consequence	A	Hoort	gos	ore.				Yea	ns
P.O. Box 687	the death certif by the attending ached for use a	Physiclan/Medical	IF FEMALE: 23b. Was decedent in the past 12 r 1 ☐ Yes 2 ☑ 9 ☐ Unknown	nonths?	23c. If yes, outcome 1	2 Fetal death	ath 3[n 5[Ectopic pregnancy Other (specify)					3d. Date of del Month	Day Ye	9ar
	uires tha signed I Id be det	by		1	rs contributing to death the	bleed	g in the u	inderlying cause giv	en in Part	1.	239. Did to			the cause of de obably 4 Dur	
Vital Records,	: The law require cate has been si , page 2 should b	ompleted	Dia	bedis	rellider	<u> </u>					24a. Was a autops perform	V	prior to death?	topsy findings a completion of ca	vailable use of
Vital	ilcian: certifica rector, p	BeC	25. Was case referr examiner?		Hospital:				100		Check only on				
70	ding Phya h. After this funeral di	tlon; To	1 Yes 2 1		28a. Date of Inju	ıry 28	Outpaties b. Time of Injury	f 28c. Injui	ry at	280	5 Reside		Other (Spec	rify)	
Division	i Si te	Certification;	2 Accident 3 Suicide 4 Homicide	6 Could no determin	ot be 28e. Place of In	jury - At home tc. (Specify)	, farm, st	reet, factory, office		-	Location (St City or Town	treet and n, State)	i Number or Ru	ral Route Numb	PB <i>r</i> ,
	To the Hospital within 24 hours a To the Funeral completely filled	Medical C	29a. Certifier (Check only one)	1 Certifying 2 Medical E	Physician: To the best xaminer: On the basis of and manner st	of my knowle of examination ated.	dge, deat and/or in	h occurred at the til vestigation, in my o	me, date a opinion, de	nd place, and ath occurred	due to the ca at the time, d	ause(s) ate and	and manner as place, and due	stated. to the cause(s)	
	To the within 2 To the comple	Me	29b. Signature and	title of certifier	QoQ MS			29c. Licens	se number	715	. 2	9d. Date	signed (Monti		
			30. Name and addre	ass of person w	nho completed cause of n.l., 100	death (Item 23	a) (Type, KLD//	Print) 51. 3	AUIS	bung	MB		202515541.0		
	Sta Regist	-	31. Date filed (Mont	h, Day, Year) 9 2004	cho completed cause of M.D., 100	rar's Signature	Sp	and !							

213-32-9792

State of Maryland / Department of Health and Mental Hygiene 2004 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) November 17, 2004 **Physician** Gretchen Martina Brandt 18:46 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Route 26 west of Georgetown Boulevard Sykesville Carroll Months Days Hours Min. (Month, Day, Year)

March 29 1988 7. Age (In yrs. last birthday) Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** Months Days 218-29-3100 1 ☐ M 27 F 16 Director Md Usual Residence of Decedent 10c. City. Town or Location 10a State 10b. County 10d. Inside City Limits 27 is marked other then "neturel", or items 23a or 28e-f show treumstic event, the Medical Examinar must be notified at MdCarroll 1 ☐ Yes 2 ☐ No Woodbine Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 1693 Village Green Drive 21797 by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. e filed within 72 hours after ual Hygiene. I hygiene." neturel', or Iter 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: Specify: white 3 Widowed 4 Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) education student 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be es 1 and 2 should be fi of Health and Mental H I item 27 Is marked ot Gary Martin Brandt Andrea Notaro Mr. & Mrs. Gary Brandt (parents) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1693 Village Green Dr., Woodbine, Md 21797 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1 Department of H Importent: If ite any injury or ot once. 1 🎇 Burial 2 □ Cremation 3 □ Removal from State Wesley Freedom Cem. ` 4 ☐ Donation 5 ☐ Other (Specify) 11-21-04 Sykesville, Md 22. Name and Address of Facility Haight Funeral Home & Chapel 21. Signature of Funeral Service License Page Haight P.O. Box 195 Sykesville, Md 21784 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Multiple Pnysician murie disease or condition resulting in death) /Medical Due to (or as a con equence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examine use as the burial-transit that initiated events attending physician and resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No jo. Month Day Year 4☐Pregnant at time of death 5 Other (specify) à 23e. Did tobacco use contribute to the cause of death? Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. þ 99 1 Yes 2 No 3 Probably 4 Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 XYes 2 □ No 24a. Was an autopsy performed? 1 Yes 2 No Hospitel or Attending Physicien: 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6XX ther (Specify) SCENE Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 X Yes 2 ☐ No this funeral 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: Driver of motor vehide that After □Natural 5 Pending after death. 2 Accident 3 Suicide investigation 6=38 1 Yes 11-17-04 6 Could not be determined 6 Could not be determined

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Road

28f. Location (Street and Number or Rural Route Number, City or Town, State) R + 36 W2st of G2C 102 PM

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 4 Homicide 24 hours a 29a. Certifier Medical 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. within 2 To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier hi O.C.M.E. November 18, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201 LING LI 31. Date filed (Month, Day, Year) NOV 1 9 2004 32 Registrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene 36675 For State Registra Fine Fig. 1983 PER FH C837 11945/1941916 Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** JUVERUBER 2004 EXKLUINE /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner AUE N/a. BATHMARK!
If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months 1 ☐ M 2 🔀 F Director 23054 5477A OCHOBER 16,1950 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits or than "natural, or Items 23a or 28a-f show the Wedical Examinating the confilled at 1 Yes 2 No by Funeral Director BA HIMURE 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? AVE 1638 Sherwerd U5.A 12. Was Decedent Ever in U.S. Armed Forceş? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Yes 27 No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗷 No Specify: Black Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. Ie marked other than Elementary/Secondary (0-12) College, (1-4or 5+) Electren, e 17. Pather's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Beaux 0185/18 CURBEAN. 2 Mary E 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 le
any injury or other trau Britimone Harylond Sherwerd hLi5 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Cility 21. Signature of Funeral Service Licensee BEAS Fune (P) Baltimers, MD 212/3 N. CAKOLINE ST Potucia Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) **Examiner** if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Be Completed by Physician/Medical Examiner sician and burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) physician at the burial Box 68760. as attending for use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.0. the þ signed l d be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 Yes 2 No 3 Probably 4 □Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an has autopsy performed? res 2 No certificate 1 Yes To the Hospitel or Attending Physicien: 25. Was case referred to medical 26. Place of Death (Check only one) examiner' 2 No Other: 4 Nursing Home 5 Sesidence 6 Other (Specify) Certification: To 1 🗌 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After Natural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu investigation 2 Accident 6 Could not be determined 3 ☐ Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month Day, Year) 32. Registrar's Signature State Registrar

Amend item#5, 10b, 18, 19a, perFh, G838, 12, 10, 04, TT State of Maryland Department of Health and Mental Hygien 000 15 1 - For Stata Registrar 36676 Certificate of Death Rag. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Year **Physician** BRYON Burnett octobes 10:15 /Medical 2004 4a. Fecility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner MARYLAND Regional HOSPITAI TRINCE If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Gerege Aurel 7. Age (In yrs. last birthday) 6. Sex Birthplace (State or Foreign Country) **Funeral** 100M 2□ F 8 Director December 24,1989 min Usuef Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location in items 23a or 28a-f show 10d. Inside City Limits Harford 1 AYes 2 No Director M.D Edge wood 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21040 1751 US.A Judy Funeral Way 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after or Department of Health and Mental Hygiene. Inportent: If item 27 is marked other then "netural", or then any injury or other treumatic event, the Medicul Exactural ance. 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 Specify: 3) ACIC 1 ☐ Yes 💥 No Specify þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Student NA SUB CORP 10 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Henrietta Burnett 9 Burnatt 1) avid Henrie Warne/Retailonship (Type Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20b. Place of Disposition (Name of cemetery, crematory or other place) Edgeword 21040 Wire MARYland 20a Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) HARFORD McMcRiAl Garden Aberdeen, Mary and 11/4/04 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Betts Funeral Tation Deals CAROline St BAITIMUTE, MARY LAND 1179 N. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to for as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last cuts Due to for as a conscouence of Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? signed by the atte Month Day Year 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No P.0. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably cate has been signated to page 2 should to 1 □ Yes 4 \(\sum \text{Unknown}\) 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? res 2 \(\subseteq \text{No.} \) Division of Vital 1N Yes To the Hospitel or Attending Physician: funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospitaf: 1 Yes 2 No 1 Inpatient 2 VER/Outpatient Certification: To 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred : After ! 5 Pending investigation Injury after death. 1 🗌 Yes 2 🗆 No 2 Accident the 6 Could not be within 24 hours after de To the Funerel Directo completely filled in by th 3 🗌 Suicide 28e. Place of fnjury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number Mehto MT 27366 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) #509 Corlege PARK MD 20740 SAltiniva AVZ EFICA MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature

DHMH 17 Rev 1/2001

State

Registrar

NOV 1 9 2004

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Manyland / Department of Health and Mental Hygiene

				State of Marylar	eparime חם / Deparime Certific				eg. NO N	11. 20	c -y -y		
			1. Decedent's Name (First, Middle, Las	it)				2. Date of Dea		Year 3. Time	Death		
	Physici /Medio		REBECCA BARBOUR				# 60 T	NOVEMB	ER 10,	2004 10	:15P		
Î	Examir	ner	4a. Facility Name (If not institution, give FUTURE CARE NUR				4b. City, Town, or L RANDALLS'		4c. County BAI				
	Funeral		Social Security Number 6. S	ex 7. Age (In yrs.		der 1 Year		8. Date of Birth (Month, Day)	Birthplace (State Country)	or Foreign			
П	Director		212-32-46/0	□ M 2CXF 9	7 Yrs. Monti	hs Days	Hours Will.	6-19-1	6-19-1907 MARYLAND				
	land ow st		Usual Residence of Decedent 10a. State 10b. County	10c. Cit	y, Town or Location			10d. Inside City Lim					
	a-fsh	cto	MD. N/A	В	ALTIMORE					1 ☐XYe	s 2□No		
	or 28	Director	10e. Street and Number		10f.	Zip Code		1	0g. Citizen of	What Country?			
	eath v	Funeral	11 W. 20th ST.	APT 11L 12. Was Decedent Ever in U	S 13 Was De	212		pecify Yes or No-	USA 14. Bad	e - American Indian,			
020	in 72 hours after death with the Maryland "natural", or frems 23a or 28a-f show ledical Examiner must be notified at		1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Divorced	Amed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		specify Cub	Hispanic Origin? (Sp an, Mexican, Puerto Specify:	Rican, etc.)		ck, White, etc.			
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121	within and than	Jup	Elementary/Secondary (0-12)		DOMES	DOMESTIC							
and	be filed tai Hygi d other	Be Co	17. Father's Name (First, Middle, Last)	UNKNOWN	HOUSE	VERT TY		ne (First, Middle, M		e) UNKNOWN			
Z	should b ind Menta i marked umatic a	To											
Mar	tra tra		19a. Informant's Name/Relationship (7) CHARLENE JOHNSO			,	and Number or Ru ITUS AVE.			State, Zip Code) RYLAND 212	07		
ā,	s 1 and f Health item 27 other ti		20a. Method of Disposition	20b. F	Place of Disposition (in the metery, crematory)			т		City or Town, State			
Ē	Pages nent of ant: If its ury or o		1 ☐ Burial 2 ☐ Oremation 3 ☐ I	Hemoval from State	TRO CREMAT			1-19-200	4 BALTO	., MARYLA	ND		
Baltimor	permit. Pa Departmen Important: eny injury once.		21. Signature of Farteral Service Litera	JONATHAN D.						ERVICE MARYLAND	21217		
			23a. Par(1. Enter the disease, or comp shock, or heart failure. List only of	lications that caused the deat one cause on each line.	h. Do not enter the m	node of dyi	ng, such as cardiac	or respiratory arre	est,	Approxima Interval Be Onset and	ate etween		
Ì	Physician /Medical		Immediate Cause (Final	14.0000	el eachie	C	1 3400-	0 \	100		200		
	Examiner		disease or condition resulting in death)	a. Atheess. Due to (c	or as e consequence	of):	uo vasa	ilal D	Seaso	2	as		
	ed sit	Examiner		b. the pe	Hersen								
	axecut n and al-tran	Exan	Sequentially list conditions, if any, leading to immediate	Due to (o	r as a consequence	of):							
09/90	tificate be executed g physician and as the burial-transit	edicai	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c Due to (o									
9	= m &			d						1			
	atth ce attend for us	Physician/N											
<u>;</u>	the de by the ached	hysi	Part II. Other significant conditions co	ntributing to death but not res	ulting in the underlyin	ig cause giv	ven in Part I.	23b. Did to	17	ontribute to the ceuse 3 Probably 4			
'n	ss that gned I be det	by P	conseria	10 21									
cords,	requir	Completed						24a. Was a perform	n autopsy ned?	24b. Were autopsy available prior completion of	rto		
2	ə has l age 2 s	dwc						, 1 □ Ye	s 2XNo	of déath?	⊘ No		
<u> </u>	an: T rtificat stor, pa	Be C	25. Was case referred to medical				26. Place of Dea	th (Check only on			Z.,		
5	hysic his ce al direc	2	I Tes 210 No		ER/Outpatient 3□		4 Nursing H	ome 5 Reside					
5	After t funera	tion:	27. Manner of Death 1 Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injui Wo: 1 □	ryat rk? Yes 2 ∐No	28d. Describe ho	w injury occur	rea			
	or Attendated after deat Director:	Certification:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined		ome, farm, street, fac	tory, office		28f. Location (St. City or Town		er or Rural Route Nu	mber,		
	To the Hospital or Attending Physician: The law requires that the death cent within 24 hours after death. To the Luneral Director: After this centificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use and application.	edical C		rsicien: To the best of my kno iner: On the basis of examina and manner steted.							(s)		
	vithir To the	¥	29b. Signature and title of certiflet	20 A Days		29c. Licens		29		(Month, Day, Year)			
i			1	The Court		D3	32158		11/13	104			
	`		30. Name and address of person who c	completed cause of deeth (Item	1 23a) (Type, Print)	11 St	#407	Baltin	010 1	MN 2122	ì		
	Sta	te	31. Date filed (Month, Day, Year)	32. Registrer's Signe	ture	<i>p</i>	1	00 30 10		1) 2100			
	Registra	~	NOV 1 9 20	1111/	. /4								

DHMH 16 Rev 6/95

			For State Registrar	State of M	aryland /	/ Depa <i>Cer</i>	irtment of F <i>tificate of l</i>	lealth and Death	Mental Hy	giené Reg. No.		36678
	₽°		Decedent's Name (First, Middle, L	ast)		-			2. Date of De	aath		3. Time of Death
	Physici /Medio		Florence Mae Cal	lahan					Novembe	er 11	2004	10:57 P™
	Examir		4a. Facility Name (If not institution, g	ive street and number)			4b. City, Town, o	r Location of Deat	h	4c.	County of Deat	h
			Carroll Hospital	Center			Westmin	ster		C	ounty	
	Funeral		Social Security Number 6.		je (In yrs. last	t birthday)	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.		rth av. Yearl	9. Birt	hplace (State or Foreign untry)
	Director 216-20-4870 1-1 78 192									7192	6 Mary	land
	and		Usual Residence of Decedent 10a, State 10b, County		10c. City, To	own or Lo	ration					10d. Inside City Limits
	sho	5		1								1 ☐ Yes 2 No
	the N 28a-f	ect	MD Carro1 10e. Street and Number	<u></u>	Sykes	svill	10f. Zip Code			10a Citi	izen of What Co	
	with	급	Golden Age Guest									
	leath	era	1442 Buckhorn Ro	12. Was Decedent	Ever in U.S.	13. V	21784 Vas Decedent of H	lispanic Origin? (S	Specify Yes or No		ed Stat	
"	r Itan	Funeral Director	1 ☐ Never Married 2 ☐ Married	Armed Forces?		1	Vas Decedent of H Yes, specify Cuba	an, Mexican, Puer	to Rican, etc.)		Black, White	e, etc.
5-0036	be filed within 72 hours after death with the Maryland tal Hygiene. Id other than "natural" or Itams 23a or 28a-f show event. The Medical Exartret rotal be notified at	þ	3 ☐ Widowed 4 ☒ Divorced	If Yes, Give Year or Dates:		1	☐ Yes 2 No	Specify:			Specity: W	hite
9	72 ho	Completed	15. Decedent's (Specify only highest g	Education	1	6a. Deced	ent's Usual Occup	ation	rkina	16b. Ki	ind of Business/	Industry
21	within 7 iene.	a du	Elementary/Secondary (0-12)	College (1-4or		life. L	OO NOT use retired	d)	iking			
2121	ygien yerth	Cou	12		Te	eleph	one Oper					one Company
nd	be fill tal Hy d oth	Be	17. Father's Name (First, Middle, Las	st)					me (First, Middle	, Maiden	Sumame)	
<u>y</u> a	ould Men Merka arka	은	Edward Doll					Mae Sta				
Maryland	12 should be filled within h and Mental Hygiene, 7 is markad other than " fraumatic evant, the Mes		19a. Informant's Name/Relationship		1		g Address (Street					(îp Code)
	l and tealth im 2 har t		Judith Esposito	Daughte			Perry Ro					Tour State
0	ges tot H ite		20a. Method of Disposition 1 □ Burial 2 ☼ Cremation 3	Removal from State	ceme	etery, cren	sition (Name of natory or other plac	ce)	Date UNK	200. Lo	ocation - City or	rown, State
altimore,	nit. Paratmen ortant: Injury B.		* 4 □ Donation 5 □ Other (Spec		South	The second	roll Cre			Win	field, 1	Maryland
Bal	permit. Pages 'Department of H Important: If ite any Injury or ot once.	y	21. Signature of Funeral Service Lic	Mar	-	Bu	Name and Addre rrier-Qu 12 W. Ol	een Fune	ral Home	& C linfi	remator	y, P.A. 21784
			23a. Part1. Enter the disease, or co shock, or heart failure. List on	vione cause on each li	ine	Do not ente	er the mode of dyin	ng, such as cardia			<u> </u>	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Clus	ue Obst	welve	Pulmay	Diseuse				Onset and Death
	/Medical		resulting in death)	Due to (or as	a consequen	nce of):						
	Examiner		Securatistly list conditions	0.	00	1 -	Pislan	R				> 1 YR
	po ii	Iner	Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequen	nce of):						
	and trans	Examln	that initiated events resulting in death) Last	C. Due to (or as	a consequen	oce of):						
60,	icate be executed physician and s the burial-transit			220 10 (6) 22	2 20112342011							
68760,	ficate be executed g physician and as the burial-transit	edlcal		d								
	eath certifu attending I I for use as		IF FEMALE:	23c. If yes, outcome	of pregnancy	y					23d. Date of deli	verv
Вох	The law requires that the death certive has been signed by the attending agge 2 should be detached for use a	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	1□Live birth 4□Pregnant a			Ectopic pregnancy Other (specify)	<i>'</i>			Month	Day Year
P.O.	that the de led by the a detached t	hysl	9 Unknown	9□ Unknown								
	res that Igned b	by P	Part II. Other significant conditions	contributing to death b	out not resultin	ng in the ur	derlying cause giv	en in Part I.	23e. Did	tobacco u	ise contribute to	the cause of death?
rg	quire on sig uld b								1 🗆	Yes 2	□No 3□Pr	obably 4 Honknown
ecords,	aw requisible been 2 should	Completed							24a. Was		24b. Were au	topsy findings available completion of cause of
R	The lav	E O							perfo	ormed?	death?	
Vital R	ysician: Th is certificate director, pag	BeC	25. Was case referred to medical					26. Place of De	ath (Check only			
of V	Q 5.	일	examiner? 1 Yes 2 No	Hospital: 1 Inpati		VOutpatien	t 3□ DOA Oth	er: 4 Nursing H	lome 5 ☐ Resi	dence	6 □Other (Spec	sify)
			27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Inju (Month, Da	ary Year) 28	3b. Time of Injury	28c. Injur Wor		28d. Describe	how injur	y occurred	
sio	tendi death. tor: A	catl	2 Accident investigat 3 Suicide 6 Could not	be				Yes 2 □No				
Division	or Attendater deatl	Certification;	4 Homicide determine	a 289. Place of In	jury - At home tc. <i>(Specify)</i>	e, farm, stre	eet, factory, office		City or To			ral Route Number,
	Hospital 24 hours 2 Funaral stely filled		29a, Certifier 1 Certifying	Physician: To the best	of my knowle	edge, death	occurred at the tir	me, date and place	a. and due to the	cause(s)	and manner as	stated.
	To the Hospital or Attending within 24 hours after death. To tha Funaral Diractor: After completely filled in by the fune	edical		aminer: On the basis of and manner st	of examination							
	To the within 2 To the complet	Σ	29b. Signature and title of certifier				29c. Licens			29d. Dat	e signed (Month	n, Day, Year)
•			taleer 7000	sur			1) 20	806		11/1	2/2004	
1)		30. Name and address of person wh	o completed cause of o	death (Item 23	3a) (Type, 1	Print) IBORTY	RO E	LDOPSBU	RG .	WD 2	21784
• 45	Sta Registi		31. Date filed (Month, Day, Year) NOV 1 9 2004	32. Registi	rar's Signature	1	Sould .					1
			MONT O COOL	2	F	7 4						

			For State Registrar	State of	Maryland / [•	rtment of tificate of			ental Hy	giene Reg. No	004	36679
	Physici	20	1. Decedent's Name (First, Middle, L	•	<u> </u>					2. Date of De			3. Time of Death
	Physici /Medio	al	Mary Catherin				4b. City, Town,	or I continu	a of Dooth	Nov	17	Gounty of Dea	7 /7 "
1	Examin	er	4a. Facility Name (If not institution, g. Marin on Health		Fir		Bel A		TOI Death			tar Rona	
	Funeral Director				. Age (In yrs. last bir	thday) Yrs.	If Under 1 Year Months Days		or 24 Hrs. Min.	8. Date of Bir (Month, Da Feb. 2	rth ay, Year) 2,19	9. Bii	thplace (State or Foreign ountry) PA
	72 hours after death with the Maryland neturel', or Hems 23a or 28a-f show dreal Examiner must be positived at		Usual Residence of Decedent 10a. State 10b. County		10c. City, Tow	n or Loc	ation						10d. Inside City Limits
		tor	Maryland Harfo	rd			Fal	lstor	ı				1 ☐ Yes 2 ☑ No
	or 28	Direc	10e. Street and Number				10f. Zip Code				10g. Cit	tizen of What C	ountry?
	eath v	erai	2300 Franklin's		Ct. lent Ever in U.S.	13. W	210		Orlain? (Spe	city Yes or N	0-	U.S.A	
5-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hyglene. Importents if item 27 is marked other then "neture", or items 23a or 28a-1 show morphorents if item 27 is marked other then "neture", or items 23a or 28a-1 show many hours or other treumatic event, the Medical Examination mat be positived at ODEs.	by Funeral Director	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Ford	ces? 2 DXNo	1	Vas Decedent of Yes, specify Cul			Rican, etc.)		Black, Whi	
5-0	72 ho netur	eted	15. Decedent's (Specify only highest g	Education rade completed)	16a.	Decede	ent's Usual Occu kind of work done OO NOT use retire	pation during m	ost of workin	ng .	16b. K	ind of Business	/Industry
2121	within ene. then "	Completed	Elementary/Secondary (0-12) 7th Grade	Coilege (1-	4or 5+)		10 NOT use retir 1emaker	∍d)				Own H	lame
	e filed at Hygi other vent, I	Be Co	17. Father's Name (First, Middle, Las	st)			·	18. Mot	her's Name	(First, Middle	, Maiden		ome
ylar	Menta Menta Marked	ToE	Cosomo Mazz						lary	DiGio			
Maryland	d 2 sh th and th and ?7 Is rr treurr		19a. Informant's Name/Relationship Mr. Harry J. Cin				g Address (Stree Frankli						
-	s 1 and Heal	1	20a. Method of Disposition		20b. Place of	Dispos	sition (Name of patory or other pla	1		ate		ocation - City or	
imo	Pages ment of H ent: If Ite ury or of		1 Burial 2 Cremation 3		tate	eu V	alleu M	em'l	11/20	/04	Time	onium,	Maruland
Elementary/Secondary (0-12) The Grade To be dead of the secondary of the													
			23a. %art1. Enter the disease, or co shock, or heart failure. List on Immediate Cause (Final				Approximate Interval Between Onset and Death						
	Physician /Medical		disease or condition resulting in death)	a. HrZ	ras a consequence		he (or	hove	Since	or de	esec	se	Jeans
П	Examiner		Sequentially list conditions.	b. Mul	lti valvul	er	Dyst	unci	hon o	I the	he	ort	years.
	ted	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (o	r as a consequence	of):	00		0	7			0
ó,	execu an and rial-tra	Exar	that initiated events resulting in death) Last	c. Due to (o	r as a consequence	of):						-	
8760	cate be executed physician and the burial-transit	dical	•	d									
9		a)	IF FEMALE: 23b. Was decedent pregnant		ome of pregnancy							23d. Date of de	livery
O. Box	0 0 0	Physician/M	in the past 12 months? 1 ☐ Yes 2 € No 9 ☐ Unknown		th 2 Fetal death nt at time of death wn		Ectopic pregnant Other (specify)					Month	Day Year
Records, P	requires that the de een signed by the a hould be detached f	by	Part II. Other significant conditions Dicos lorice	contributing to dea	ath but not resulting in	n the un	derlying cause g	ven in Par	<u> </u>				o the cause of death? robably 4 Dunknown
eco	Q 10	Completed	Pulmonony	Hype	Tensib	<u>/</u>				24a. Was	DSV	prior to	utopsy findings available completion of cause of
al R	The ite h		Chronic De	bothnet	we Pulm	one	y dis	ecs		1 ☐ Yes		death?	3 2 □ No
Vital	Physiclen: Th r this certificate ral director, pag	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 1 ☐ No	Hospital: 1 □ In	patient 2 ☐ ER/Ou	tnatient	3□ DOA O	100000		(Check only one 5 □ Resi		6 □Other (Spe	acifu)
o	ding Phy h, After this funeral d	n; To	27. Manner of Death 1 XNatural 5 Pending	28a. Date of		Time of	28c. inju			8d. Describe			<i>City</i>
Division	Attending ir death, ector: After by the fune	catic	2 Accident investigati	on			M 1 [Yes 2		104 Leastine /	Street on	ad Alumbas as O	ural Route Number,
Divi	after of Direction by	Certification;	4 Homicide determine	d 200. Flace	of Injury - At home, fa g, etc. <i>(Specify)</i>	ırm, stre	et, factory, office			City or To			urar noute reamber,
	To the Hospitel or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the fu	Medical C	29a. Certifier 1 Certifying I (Check only one) 2 Medical Ex	Physician: To the taminer: On the base and manner	pest of my knowledge sis of examination an er stated.	e, death	occurred at the testigation, in my	ime, date a	and place, a	and due to the ed at the time,	cause(s) date and	and manner a d place, and due	s stated. e to the cause(s)
	To th withir To th comp	Me	29b. Signature and title of certifier	als			29c. Licer	se numbe			29d. Dat	te signed (Moni	17 1th, 2004
•	5		,					اکارر	50,		140		, 2004
$\frac{1}{2}$	1			PLO.#	205, 60	(Type, F	S. ATW	000	Rd.	BEL	AD	R, MD	21014
	Sta Registi		31. Date filed (Month, Day, Year) NOV 1 9 2004	22. Ro	gistrar's Signator	de	sould						

Amend item#1, Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene 2004 1 - For Stete Registrer 36680 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Arthur Robert Crusse Month Year **Physician** DULOM Arhtur Robert Crusse November 18 2004 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Bel Air Harford Upper Chesapeake Health Center 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) July 13, 1929 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** 1**X** M 2□ F Maryland Director 216 24 7315 Usual Residence of Decedent 10c. City. Town or Location 10a. State 10h County 10d. Inside City Limits 28e-f show other traumetic event, the Medical Examinar must be notified at 1 ☐ Yes 2 No Maryland Baltimore Essex Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21221 1406 Nicolay Way USA 239 by Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑Yes 2 ☐ No If Yes, Give Year or Dates: 1951/53 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 ō 1 ☐ Yes 2 No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Dairy Manager Grocery Store 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mental and Mental Elizabeth Zulauf Edward A. Crusse 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1406 Nicolay Way Baltimore, Md. 21221 Ethel Marie Crusse (Wife) Department of Health Important: If Item 27 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Bayview Crematory 11/19/2004 Baltimore, Maryland * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Bruzdzinski Funeral Home P.A. 21. Signature of Funeral Service Lipensee 1407 Old Eastern Avenue Essex, Md. 21221 23a Pa/1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, strock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CYARR **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner PANCYTOPENIA Sequentially list conditions, Due to for as a nonsequence of cause (Disease or injury that initiated events resulting in death) Last 5YAS MYELODYSPLASTIC SYNDROME use as the burial-tran Due to (or as a consequence of): 68760 Physician/Medical Box (IF FEMALE 23c. If yes, outcome of pregnancy
1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) P.O. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ COROMARY ARTERY DISEASE INFECTION 1 Yes 2 No 3 Probably 4 thinknown page 2 should Be Completed 24a. Was an autopsy performe VASCULAR 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 1 Yes 2 No Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) examiner Hospital: 1 Enpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Hospital or Attending 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident after death 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours at To the Funeral D completely filled in 29a. Certifier 1 🕱 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29b. Signature and title of certifies 29c. License number 30. Name and a dress of person who complete cause of death (Item 23a) (Type, Print) JOHN BYRNE BEL AUR UPPER CHESAPER 50 o 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

NOV 1 9 2004

04. RJ	-07365		1- State Unpend Item	State of Maryland / E 23a&27 per me G839	Department of Health and	d Mental Hygie	ne 2001.	36601
	Physici /Medic		1. Decedent's Name (First, Middle, William	Cheathan		2. Date of Death Month November	Day Year 15, 2004	3. Time of Death 08:42 P.M.
	Examin	er	4a. Facility Name (If not institution, g Washington Count		4b. City, Town, or Location of De Hagerstown	eath	4c. County of Death	
3	Funeral Director			. Sex 7. Age (In yrs. last bird		in. S. Date of Birth (Month, Day, Y.)	969 Mc	hplace (State or Foreign untry)
,	anyland show	_	10a. State 10b. County	10c. City, Town	. 1.			10d. Inside City Limits
	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene, item 27 is marked other then "neturel", or items 23e or 28e-1 show other treumetic event, it is M-dical Evir instrumetic event, it is M-dical Evir instruments.	Funeral Director	10e. Street and Number	t Ba	10t. Zip Code	10g	. Citizen of What Co	1 Yes 2 □ No untry?
	ems 23	ıneral	11. Marital Status	12. Was Deceded Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pu	(Specify Yes or No-	14. Race - Amer	
5-0036	hours after turel', or ite	þ	1 Never Married 2 Married 3 Widowed 4 Divorced	1 Yes 2 No If Yes, Give Year or Dates:	1 ☐ Yes 2 🗓 No Specify:	, , , , , , , , , , , , , , , , , , , ,	Specify: B	acK
215-0	in 72 ho n "netur	Completed	15. Decedent's (Specify only highest)	grade completed)	Decedent's Usual Occupation (Give kind of work done during most of viife. DO NOT use retired)	working 16	b. Kind of Business/l	ndustry
2	iled with Tygiene ther the		Elementary/Secondary (0-12) 17. Father's Name (First, Middle, La	College (1-4or 5+)	Laborer	Name (First, Middle, Ma.	Hopkin	s Hosp
Maryland	should be filed withir nd Mental Hygiene. marked other then imetic event, ITE M.	To Be	William	Cheatham	Sr. Eva	ingelin	ie Ch	eatham
Mar	nd 2 sho alth and 27 Is ma r treum		19a. Informant's Name/Relationship	(Type, Print) 196. Teline. Cheathain	Mailing Address (Street and Number or 2016 W. Sal	Rural Route Number, C	ity or Town, State, Z	ip Code) 2/22
lore,	B = 10		20a. Method of Disposition 1 Burial 2 Cremation 3	☐Removal from State	Disposition (Name of y, crematory or other place)	Date 200	c. Location - City or I	fown, State
Baltimore,	permit. Page Department of Importent: If eny injury or once.	ij	. 4 □ Donation 5 □ Other (Spe		22. Name and Address of Facility Joseph L. Rus	s Funer	saltons	<u> 1110.</u>
Ī	45240		23a. Part1 Enter the disease, or co	omplications that caused the death. Do n	ot enter the mode of dying, such as card	Ave. Ba	Ito. Md.	Approximate Interval Between
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	Atherosclerotic	Cardiovascular Dis			Onset and Death
L	Examiner	_	Sequentially list conditions,	Due to (or as a consequence of	·			
	and I-transit	Examiner	Sequentially list conditions, if any, leading to immediate cass. Enter underlying Cause (Disease or injury that initiated events	Due to (or as a consequence of	n):			
8760,	be ey ician buria	dlcal Ex	resulting in death) Last	Due to (or as a consequence of	ff):			
9	eath certificate attending physi for use as the	o ·	IF FEMALE:	23c. If yes, outcome of pregnancy			22d Date of dalls	
O. Box	0 0 0	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	1 Live birth 2 □ Fetal déath 4 □ Pregnant at time of death 9 □ Unknown	3 □Ectopic pregnancy 5 □ Other (specify)		23d. Date of deliver Month	Day Year
ls, P.O.	requires that the de een signed by the a nould be detached f	by	Part II. Dther significant conditions	s contributing to death but not resulting in	the underlying cause given in Part I.		co use contribute to	
Records,	v requi	Completed				1 ☐ Yes 24a. Was an	2 No 3 □ Pro 24b. Were aut	opsy findings available
al Re	The ate h page					autopsy performed Yes 2	d? prior to co	ompletion of cause of 2□ No
f Vital	dis dis	To Be	25. Was case referred to medical examiner? 1 ☒ Yes2 ☐ No	Hospital: 1 ☐ Inpatient 2 ER/Out	0.4	eath <i>Check onl</i> one Home 5 Residence	e 6 □Other (Spec	ify)
on of	fing After fune		27. Manner of Death 1 XNatural 5 Pending 2 Accident investigat			28d. Describe how i		
Division	To the Hospitel or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the fu	Certification:	3 Suicide 6 Could not determine	be Des Bless of Injury At home for	m, street, factory, office	28f. Location (Stree City or Town, S	t and Number or Rur late)	al Route Number,
	To the Hospitel or At within 24 hours after d To the Funerel Direct completely filled in by	edical C	29a. Certifier 1 ☐ Certifying (Check only one) 2 ☑ Medicel Ex	Physicien: To the best of my knowledge, aminer: On the basis of examination and and manner stated.	death occurred at the time, date and pla dor investigation, in my opinion, death oc	ce, and due to the caus courred at the time, date	e(s) and manner as s and place, and due t	stated. to the cause(s)
b	To th withir To th comp	Me	29b. Signature and title of certifie	As a Mr	29c. License number OCME		Date signed (Month,	
			30. Name and address of person wh	o completed au e of death (Item 23a) (Type, Print)			, 2501
	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's Signature	Penn Street, Baltim	ore, maryla	mx7 51501	
DH	Registr	ar	NOV 1 9	2004 Been &	fort			580
	/ 1134 1/21				9 -			

ORIGINAL

			Please		ack Indelible Ink. Ensure	_	
			For State Registrar	State of Maryland	/ Department of Health and Certificate of Death	Mental Hygie	2004 36682
	Physici		1. Decedent's Name (First, Middle, La:	Colh	Tr	2. Date of Death Month Novemb	Day Year 9:05 M
	/Medic Examin		4a Fecility Name (If not institution, give	LD LD	4b. City, Town, or Location of Dec	ath	4c. County of Death
Ī	Funeral Director		5. Social Security Number 6. S	100 01 D	of birthday) If Under 1 Year If Under 24 H. Yrs. Months Days Hours Mi		9. Birthplace (State or Foreign
	D		Usuel Residence of Decedent 10a. State 10b. County	10c. City,	Town or Location	Sept.12,	10d. Inside City Limits
	death with the Maryland ims 23a or 28a-f show if must be notified at	ector	Maryland N/F	\mathbb{R}	baltimore	100	1 Yes 2 No
	ath with s 23a or ust be	rai Dir	800 W. Le	xington S	t.3 21201		USA
36	s after de or items	y Fune	11. Marital Status 1 Never Married 2 Married	12. Was Nebedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give	13. Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pue 1 ☐ Yes 2 X No Specify:	(Specify Yes or No- erto Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify:
5-0036	72 hours after natural', or Ite	eted b	3 Widowed 4 Divorced 15. Decedent's Edition (Specify only highest gradult)	year or Dates:	16a. Decedent's Usual Occupation (Give kind of work done during most of w	orking 16b	b. Kind of Business/Industry
2121	s 1 and 2 should be filed within 72 hours after death with the Marylan if Health and Mental Hygiene the factor of terms 23a or 28a-1 show item 27 is marked other than "natural", or items 23a or 28a-1 show other traumatic avant. The Modical Examber must be notified at	Completed by Funeral Director	Elementary/Secondary (0-12)	College (1-4or 5+)	Clerk	Be	elvedere Cleaners
land	ould be file Mental Hy arked oth	To Be (17. Father's Name (First, Middle, Last)	b	18. Mother's N	ame (First, Middle, Maid P. MUP e	den Sumame)
Maryland	nd 2 shouth and N		19a. Informant's Name/Relationship (Type, Print) (Sister)	19b. Mailing Address (Street and Number or I	Rural Route Number, Cit	ity or Town, State, Zip Code) 21014
iore,	8 = 5		20a. Method of Disposition 1 Burial 2 Cremation 3	Removal from State	ce of Disposition (Name of petery, crematory or other place)	Date 20c	Location - City or Town, State
Baltimore	permit. Pages 1 and Department of Health Important: if itam 27 any injury or other tr once.		4 □ Donation 5 □ Other (Specifical Service Piper		OUTUS Mem. PK.	< Funer	sal Home
	₫ O 'E @ O		23a. Part1 Inter the disease, or com	plications that caused the death.	Do not enter the mode of dying, such as cardi	Ave. Ba	Approximate Interval Between
	Priysician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. OLOM Due to (or as a conseque)	CANCER		Onset and Death JORN
	Examiner	Pe	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a conseque			<i>U</i>
Vit	executed an and rial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c			
68760,	certificate be ex ding physician se as the buria		· ·	d			
Вох	w requires that the death certificate be been signed by the attending physicis should be detached for use as the bu	by Physician/Medicai	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 0 No	23c. If yes, outcome of pregnanc 1 Live birth 2 Fetal de 4 Pregnant at time of deal	eath 3 Ectopic pregnancy		23d. Date of delivery Month Day Year
, P.O.	requires that the death een signed by the atter hould be detached for u	y Phys	9 Unknown	9□ Unknown ontributing to death but not resulti	ng in the underlying cause given in Part I.	23e. Did tobacc	co use contribute to the cause of death?
ords	requires been sign should be	eted b				1 Tyes	2 No 3 Probably 4 Unknown
Vital Records,	The lay ate has page 2	Completed				24a. Was an autopsy performed	
f Vita	Physician: Th this certificate ral director, pag	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐ EF	Othor	eath (Check only one) Home 5 Residence	6 Nother (Specify) 40 Spice
Division of	nding Ph th. : After th s funeral		27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	(Month, Day Year)	8b. Time of lnjury 28c. Injury at Work? M 1 Yes 2 No	28d. Describe how in	njury occurred
Divis	i or Attai after dea Diractor	Certification:	3 Suicide 6 Could not b 4 Homicide determined	28e. Place of Injury - At hom building, etc. (Specify)	e, farm, street, factory, office	28f. Location (Street City or Town, St	t and Number or Rural Route Number, tate)
	To the Hospital or Attanding Phys within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral di	Medicai C	29a. Certifier (Check only one)	ysicien: To the best of my knowle niner: On the basis of examination and manner stated.	edge, death occurred at the time, date and plan n and/or investigation, in my opinion, death oc	ce, and due to the cause curred at the time, date	e(s) and manner as stated. and place, and due to the cause(s)
	To the within To the	Me	29b. Signature and title of certifier	1 10	29c. License number D25205		Date signed (Morith, Day, Year) Oscuber 16, 2004
	3		30. Name and address of person who	completed cause of death (frem 2	3a) (Type, Print)		
	2		31. Date filed (Month, Day, Year)	32. Registrar's Signatur	3a) (Type, Print) N. Choles St. B		
	Sta Registr		NOV 1 9 2	004 Genera	M Ann V.		

			for State Registrar	State	of Maryla			ent of H		d Me		iene _{eg. Nor}			
I	Physici		Dorothy Tool:	die, Last) in Daught	rey	-				2.	Date of Deat Month	h Day	UU4 Year	्छे⊤(1	1:25a ^M
ı	/Medic Examin		4a. Facility Name (If not institut. Shady Grove	ion, give street and l Adventist	number) Hospit	al		y, Town, or Rockv	Location of D	Peath			County of Dea		
	Funeral Director		5. Social Security Number 231-07-1824	6. Sex 1 ☐ M 3/□ XF	7. Age (In yr. 89	s. <i>last birthday)</i> Yrs.	If Und Month	ler 1 Year s Days	If Under 24 I Hours N	Vin.	Date of Birth (Month, Day,	Year)	9. Bir		ate or Foreign
	and **		Usual Residence of Decedent 10a. State 10b. Coun	tv	10c. 0	City, Town or Lo	ncation								la Cita Limita
	Maryla	ō		gomery	100.	, round E	zoation]	Montgon	nerv	Villad	re			le City Limits Xes 2 ⊡ No
	with the 3a or 28a-	i Director	10e. Street and Number 19310 Clubhou	ise Road			10f. 2	Zip Code		0886			en of What Co		
36	should be filed within 72 hours after death with the Maryland of Mental Hygiene. marked other than "natural", or items 23s or 28s-f show imatic event, the Medical Exanter mast be routhed at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Ma 3 ▼ Widowed 4 □ Divorce	Armed 1 TYe	ecedent Ever in Forces? s 2 X No Give Dates:		If Yes, s	edent of Hi becify Cuba	spanic Origin? n, Mexican, Po Specify:	? (Specifi uerto Ric	y Yes or No- can, etc.)		4. Race - Ame Black, Whit		
2-0036	2 hours	ted t	15. Decede	ent's Education		16a. Dece	dent's Us	sual Occupa	ation			16b. Kin	d of Business		
21215	within 72 ene. than "nat	Completed	Elementary/Secondary (0-12)	est grade complete College	d) + (1-4or 5+)	(Give	kind of v DO NOT	vork done d use retired	furing most of)	working					
2	filed w Hygien other th		12 17. Father's Name (First, Middle	(a at)	0		Ho	usewi					Own Hor	ne	
aryland	should be find Mental H marked of umatic ever	To Be	Joseph F.	Tooli	.n				M	Mary		Summ	ers		
>	and 2 sh ealth and m 27 is m		19a. Informant's Name/Relation Dorothy McDer	1 1 21 1		1771	.6 Sr	nokewo					Town, State, 2 n Mary]		20874
altimore,	permit. Pages 1 and 2 should by Department of Health and Menta Important: If item 27 is marked any injury or other traumatic evonce.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other	(Specify)	m State Me	Place of Dispo cemetery, crer adowbrook	matory of	r other place	ardens	Date	8/04		ation - City or	Town, Stat VA	Ð
Balt	permit. Depart Import any inj		21. Signature of Funeral Service	Vict	ens P. Dod		harl	es L. S	s of Facility Stevens I ort. Aveni	Funera De. B	al Home,	Inc	• vland 2	1230	
			23a. Part1. Enter the disease, shock, or heart failure. Li	or complications tha st only one cause or	t caused the dea	ath. Do not ent	er the m	ode of dying	, such as card	diac or re	espiratory arre	st,	, D. L.	Approxi Interval	Between
	Physician		Immediate Cause (Final disease or condition resulting in death)	_ a O	Spire	hov	0	NEL.	(WO	Lita				Onset a	nd Death
H	/Medical Examiner		resulting an death,	Due t	o (or a) a conse	equence of):	1		L'C					4	(>
		Jer	Sequentially list conditions,	b. — Due t	(or as a cons	quence of):	OPV	iadi.	17>				-	115	٠
	icate be executed physician and s the burial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c			·							11790	
60,	be exe		rosulting in deathy East	Due	o (or as a conse	quence of):									
68760	ficate g phys is the	edicai		d.											
ROX	eath certific attending p	M/W	IF FEMALE: 23b. Was decedent pregnant		outcome of preg		Testonio					23	3d. Date of deli	very	
Ö	0 0	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		gnant at time of		Other (pregnancy s <i>pecify)</i>					Month	Day	Year
<u> </u>	res that igned b	by Pr	Part II. Other significant condi-	tions contributing to	death but not re	sulting in the ur	nderlying	cause give	n in Part I.		23e. Did toba	acco us	e contribute to	the cause	of death?
ord	w require been si should b									-	1 🗆 Yes	s 2 🗆	lNo 3□Pro	obably 4	XX nknown
Vital Records,	The lar ate has page 2	Completed								_	24a. Was an autopsy perform	'	24b. Were au prior to death?	topsy findir ompletion (2 \(\frac{1}{2}\)	gs available of cause of
/Ita	sicien: Th certificate rector, pag	Be (25. Was case referred to medic examiner?							Death (C	heck only one			- 21	
	Physi this c	. To	1 ☐ Yes 2 22 No 27. Manner of Death		Mnpatient 2[e of Injury	ER/Outpatien			# 🖂 IARIENI				Other (Spec	rify) /-	
0	ding I th. : After funer	tion	1 XNatural 5 ☐ Pend	/A A-	onth, Day Year)	Injury	м	28c. Injury Work 1 Y	at ? ′es 2.⊟No	280.	. Describe how	w injury	occurred		
Division of	or Attending Physicien: witer death. Director: After this certific in by the funeral director,	Certification:	3 ☐ Suicide 6 ☐ Could	not be 28e. Pla	ce of Injury - At I	nome, farm, stre	eet, facto			28f.	Location (Stre	et and	Number or Ru	ral Route N	lumber,
5	spital or ours afte nerel Dir filled in	Cert	- Inditional	, Jul	ding, etc. (Spec	y)					City or Town,	State)			
	To the Hospital or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the fu	Medical	29a. Certifier 1 Certify (Check only one) 2 Medica	ing Physician: To to I Examiner: On the and ma	ne best of my kr basis of examin inner stated.	owledge, death ation and/or inv	occurre estigatio	d at the time on, in my op	e, date and pla inion, death oc	ace, and ccurred a	due to the car at the time, da	use(s) a te and p	nd manner as place, and due	stated. to the caus	e(s)
	Vith To T	2	29b. Signature and title of certification	er la . O .			2	9c. License	-				signed (Month		
	7	-		Jarry				D 3	3341		M	OVCV	mber	14	2004
			30. Name and address of person Suhair Abulfarag	yno completed ca y MD 15215	Shady Gr	m 23a) (Type, l ove Road	# 10	O, Roci	wille M	aryla	nd 2085	50			
	Sta Registr	_	31. Date filed (Month, Day, Yea		Registrar's Sign										

			1 - For State Registrar	State of Maryland		artment of H		Re	g. No.2 1 1 1.	3668h
	Physicia		1. Decedent's Name (First, Middle, Las Lucille Dargar					2. Date of Death Month 11/14	Day Year	7:05a M
	/Medic Examin		4a. Facility Name (If not institution, give			4b. City, Town, or			4c. County of Dea	th
			Manor Care Nur 5. Social Security Number 6. S.		et hirthday)	Largo	, MD	Hrs. 8 Date of Birth		Georges
	Funeral Director			□ M X □ XF 88	Yrs.	Months Days	Hours	Hrs. 8. Date of Birth (Month, Day, 08/12/	16	thplace (State or Foreign ountry)
	and w		Usual Residence of Decedent 10a, State 10b, County	10c. City,	Town or Lo	ocation				10d. Inside City Limits
	Maryla	tor	MD Prince	Georges	Lanh	am				1 🔯 Yes 2 □ No
	or 28e	Director	10e. Street and Number	·		10f. Zip Code			g. Citizen of What C	ountry?
	ss 23e		8809 Braeside	2 Drive 12. Was Decedent Ever in U.S.	13		20706		USA 14. Race - Am	erican Indian.
9	72 hours after death with the Maryland "naturel", or items 23e or 28e-1 show	Funeral	1 Never Married 2 Married	Armed Forces? 1 Yes 2 No If Yes, Give		If Yes, specify Cuba 1 ☐ Yes 2○€No	n, Mexican, Specify:	n? (Specify Yes or No- Puerto Rican, etc.)	Black, Whi	te, etc.
21215-0036	hours turel;	ed by	3XXVidowed 4 ☐ Divorced 15. Decedent's Ed	Year or Dates:		dent's Usual Occup			Specify: B	lack
215	c	Completed	(Specify only highest gra		(Give	kind of work done of DO NOT use retired	during most of	of working	ob. Kind of business	windostry
21	e filed withir Il Hygiene. other then vent. the M	Сош	8	0		Dames		a blama /First bliddle b		ate Home
Maryland	be d d	To Be	17. Father's Name (First, Middle, Last) Burrel Jame				18. Mother	s Name (First, Middle, N Ti		obs
Mar	and and ls m		19a. Informant's Name/Relationship (Mary Jeffery					or Rural Route Number, r. Lanham		
			20a. Method of Disposition	Cer	netery, cre	osition (Name of matory or other place	ce)		0c. Location - City or	
Baltimore,	permit. Pages Department of I Importent: If it eny injury or o once.		1 ☐ Burial 2 ☐ Cremation 3 🗶 1 ☐ Donation 5 ☐ Other (Specify	new.				metery 11/20/0	4 Bishopvill	le, SC
Bal	Depar Impor eny ir		21. Signature of Funeral Service Licer	See Victor P. Doda,	C	2. Name and Addres harles L. S	tevens	Funeral Home, De Baltimore N	Inc.	
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that saused the death. one cause on each line.						Approximate Interval Between
4	Physician		Immediate Cause (Final disease or condition resulting in death)	. PNEUM	01	. 4	2014			Onset and Death
	/Medical Examiner			Pene to (or as a conseque	ence of):					F
	p #	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a conseque	ence of):	1				
	be executed sician and burial-transit	Examiner	that initiated events resulting in death) Last	cDue to (or as a conseque	ence of):					
0928	ate be e nysician he buria	icai E		_ d						
99	leath certifical attending phy I for use as th		IF FEMALE:	23c. If yes, outcome of pregnan-	OV			dir	224 5-4	
.O. Box	0 0 0	Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 □ Yes ② No 9 □ Unknown	1 Live birth 2 Fetal of 4 Pregnant at time of dea 9 Unknown	death 3	⊒Ectopic pregnancy ⊒ Other (specify)			23d. Date of de Month	Day Year
S, D	law requires that the de as been signed by the a 2 should be detached f	by	Part II. Other significant conditions of	contributing to death but not result	ting in the u	ınderlying cause gıv	en in Part I.			o the cause of death?
Record	w requir been si should	eted						1 ☐ Ye		utopsy findings available
Rec	The law ate has page 2 :	Completed						autopsy perform	/ prior to	completion of cause of
Vital	Physiclen: The I this certificate har ral director, page	Be	25. Was case referred to medical examiner?	Hospital:		ot 3 DOA Oth	00	of Death (Check only one		
of		7: To	1 Yes 2 A Ko	1 □ Inpatient 2 □ E	R/Outpatie 28b. Time c	III 3 DOA	4 (Truis	ang Home 5 ☐ Reside 28d. Describe ho		ecify)
ion	Attending For death. Sector: After by the funer	atlor	1 Vatural 5 Pending investigatio	n	Injury		k? Yes 2 □ N	0		
Division	after de Directo	Certification:	3 Suicide 6 Could not b 4 Homicide determined	28e. Place of Injury - At hon building, etc. (Specify)	ne, farm, st	reet, factory, office		28f. Location (Str City or Town	eet and Number or R , State)	lural Route Number,
	To the Hospitel or Attenc within 24 hours after death To the Funerel Director: completely filled in by the	Medical C		nysician: To the best of my know miner: On the basis of examination and manner stated.						
	within 2 To the comple	Me	29b. Signature and title of certifier			29c. Licens	e number	29	d. Date signed (Mon	th, Day, Year)
	1				p	10 DS	5818	2 1	1-11-0	
	0		30. Name and address of person who Dr. C. Donald George	completed cause of death (Item : MD 7305 Hanover I			œlt Mar	yland 20770		
1	Sta Regist	ate rar	31. Date filed (Month, Day, Year) NOV 1 9 2004	22. Registrar's Signatu						

State of Maryland / Department of Health and Mental Hygienes 1 - For State Registrar 36685 Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 740 PM EE DORSEY NOVEMBER 8 ONNIE 2004 /Medical 4a. Facility Name (If not institution, give street and number)

PLEASANT VIEW NURSING HOME 4c. County of Deeth 4h. City. Town or Location of Death Examiner CARROLL 4101 OIB NATIONAL PIKE MT AIR Y
If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. 1⊠M 2□F Yrs. Director 218-76-6260 51 March 28, 1953 Maryland Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits or Items 23s or 28s-f show other roust be notified at 1 Yes 2X No MD Carrol1 Woodbine Direct 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 7115 Woodbine Road 21797 United States death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 X Never Married 2 ☐ Married 5 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White þ 3 Widowed 4 Divorced "naturel", Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a, Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) N/A College (1-4or 5+) Disabled None other permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if item 27 is marked othen any injury or other traumatic event 9068: 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Raymond N. Dorsey Grace E. Fleming 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Raymond N. Dorsey Father 7115 Woodbine Road Woodbine, MD 21797 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ▼ Burial 2 □ Cremation 3 □ Removal from State

'4 □ Donation 5 □ Other (Specify) Nov. 12, Lake View Mem. Park Sykesville, Maryland 2004 21. Signature of Funeral Service Licensee 22. Name and Address of Facility -Queen Funeral Home & Crematory, P.A. Old Liberty Road Winfield, MD 21784 Burrier-1212 W. Cold 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) clospidum difficile **Physician** SEPJICEMIA weeks /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that intiated events resulting in death) Last Due to (or as a consequence of) Examiner physician and the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month Day 4 Pregnant at time of death 5 Other (specify) the 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 十以be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed been 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No has autopsy performed? page 2 40 this certificate 600V 1 Yes or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Aursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After 5 Pending Injury 1 ☐ Yes 2 ☐ No investigation 2 Accident within 24 hours after death To the Funeral Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) In by 4 Homicide Tecritying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Z Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29c. License numbe 29d. Date signed (Month, Pay, Year) 29b. Signature and title of certifie 11 M MYSZO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9501 Old ANN ADOL > DO IVE
31. Date filed (Month, Day, Xear)
32. Registrar's Signarday 21842 Registrar

home

and manner stated.

Amend item#23a-c,25,27,28a-f, per ME, G837,11717/04, TT State of Maryland / Department of Health and Mental Hygiene

Jonathan Eugene Downing

7. Age (In yrs, last birthday)

10c. City, Town or Location

52

Certificate of Death

4b. City, Town, or Location of Death

BALTIMORE If Under 1 Year If Under 24 Hrs.
Months Days Hours Min.

Days

Months

Approximate Interval Between Onset and Death DAYS CERTIFICATION APPROVED BY MEDICAL EXAMINER YEARS 23d. Date of delivery Month 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed? 1 ☐ Yes 2 🗖 No 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☒ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 1 🗌 Yes Unk. Subject fell 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 307 Gwynn Avenue Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number 29d. Date signed (Month, Day, Year) P17008 JUNE 17, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dept. of Surgery Baltimore, MD 21229 900 Caton Avenue 32. Registrar's Signature **ORIGINAL**

004

Year

Race - American Indian, Black, White, etc.

Private Co.

Black

2004

4c. County of Death

1435

9. Birthplace (State or Foreign

10d. Ipside City Limits

1 ☐ Yes 2 ☐ No

Reg. No.

17

2. Date of Death Month

8. Date of Birth (Month, Pay 392) Feb 4, 1952

JUNE

Registrar DHMH 17 Rev 1/2001

within 24 hours a To the Funeral L

3 🗌 Suicide

29a. Certifier

SYLWIA

Medical

State

4 Homicide

(Check only one)

29b. Signature and little of certifier

31. Date filed (Month, Day, Year)

6 Could not be determined

mslew , MD

KARPINSKI, MD

NOV 1 7 2004

1 - For State Registrar

10a. State

5. Social Security Number

217-56-7591 Usual Residence of Decedent

Physician

/Medical

Examiner

Funeral

Director

1. Decedent's Name (First, Middle, Last)

4a. Facility Name (If not institution, give street and number)

№ М 2 Б

ST. AGNESHOSPITAL

10b. County

	ian	Decedent's Name (First, Middle, La	,				2. Date of Deat Month		3. Time of Death
/Medi	cal	MARY		DIZE			November 1		8:42 A
Exami	ner	4a. Facility Name (If not institution, given 26370 Franklin La			4b. City, Fown, o	r Location of Death		4c. County of De	
Funeral		Social Security Number	Sex 7. Ag	e (In yrs. last birthday	y) If Under 1 Year	If Under 24 Hrs.	8. Date of Birth		Birthplace (State or Forei Country)
Director		210-34-7333	1 □ M 2 🛣 F	54 Yrs.	Months Days	Hours Min.	(Month, Day, November		Country) Maryland
MO M		Usuel Residence of Decedent 10a. State 10b. County		10c. City, Town or L	Location				10d. Inside City Limi
H H	ţō	Maryland Somer	rset	Cri	sfield				1 ☐ Yes 2 📆 N
or 28.	Director	10e. Street and Number			10f. Zip Code		10	g. Citizen of What	Country?
a 23a	rai	26370 Franklin La	T		2181			U.S.A.	
Item	Funerai	11. Marital Status 1 ☐ Never Married 2X Married	12. Was Decedent Armed Forces? 1 ☐ Yes 2 [X]		. Was Decedent of H If Yes, specify Cuba	lispanic Origin? (Spann, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ar Black, Wi	merican Indian, hite, etc.
P. C.	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	10	1 ☐ Yes 2 🖾 No	Specify:		Specify: [v	∛hite
d other than "natural", or frema 23s or 28s-f show evant, the Madical Examiner must be notified at	Completed	15. Decedent's E (Specify only highest gra	ducation	16a. Dece	edent's Usual Occup	ation	ing	6b. Kind of Busines	ss/Industry
han e Ma	mpi	Elementary/Secondary (0-12)	College (1-4or 5	0+)	e kind of work done of DO NOT use retired	d)			
ther t	e Co	9 17. Father's Name (First, Middle, Last))		Assembly	18. Mother's Name		Food Proc	cessing
	To Be	Joseph Cullen				Jewell E		<i>laiden Sum</i> ame)	
Item 27 Is marke other traumatic	-	19a. Informant's Name/Relationship (Type, Print)	19b. Mail	ling Address (Street a			City or Town, State	, Zip Code)
er tra		Edward V. Dize (H	Husband)						land 21817
or othe		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐	Removal from State	20b. Place of Disp				Oc. Location - City of	
ortant: injury o		'4 □Donation 5 □ Other (Specify	y)	Sunnyridge 1	Memorial Par	k Nov. 1	.9, 2004 Cr	risfield,	Maryland
mportant: any injury once.		21. Signature of Funeral Service Licer	In Short	Sitt 1	radshaw 8				•
7 = 0		Mary Beth Br	adshaw—Pru	itt 3	306 W. Mai	n Street	- Crisf	ield, Mar	yland 2181
ysician Aedical aminer		Immediate Cause (Final disease or condition resulting in death)	Speto for as	astoctive a consecution of the second	Non-	g, such as cardiac of Small G taction	ell hu	ng Canal	Approximate Interval Between Onset and Death
dedical aminer	ai Examiner	Immediate Cause (Final disease or condition	b. Due to (or as a	25 Toche	Non-	small u	ell hu	ng Canac Lefit rus	Interval Between
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ORIGINAL

				State of Maryland / Department of State of Maryland / Department / Dep		ental Hygier Reg. ۱	
		Physici		1. Decedent's Name (First, Middle, Last) Dennis Joseph Dunn, Jr.		2. Date of Death Month NOVEMBER	ZUUL BIE BOBUS
		/Medio			wn, or Location of Death Air		4c. County of Death Harford
		Funeral Director		$\begin{array}{cccccccccccccccccccccccccccccccccccc$	Year If Under 24 Hrs. Days Hours Min.	8. Date of Birth (Month, Day, Yea July 30,	9. Birthplace (State or Foreign Country) 1918 Pennsylvania
		Maryland -f show	tor	10a. State 10b. County 10c. City, Town or Location Maryland Harford Bel Air			10d. Inside City Limits 1 ☐ Yes 2 ☐ No
		with the	al Director	10e. Street and Number 10f. Zip Co 528 North Hickory Avenue 2	21014	10g. (Citizen of What Country?
124	980	be filed within 72 hours after death with the Maryland ital Hyglene. d other then "natural", or teems 23s or 28s-f show event, tre Madical Exertine ruist by ricitified at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 ─ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent Ever in U.S. Armed Forces? 15. Was Decedent Ever in U.S. Armed Forces? 16. Yes, Specify 17. Was Decedent Ever in U.S. Armed Forces? 18. Was Decedent Ever in U.S. Armed Forces? 19. Was Decedent Ever in U.S. Armed Forces? 19. Was Decedent Ever in U.S. Armed Forces? 10. Was Decedent Ever in U.S. Armed Forces? 11. Was Decedent Ever in U.S. Armed Forces? 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent Ever in U.S. Armed Forces? 14. Was Decedent Ever in U.S. Armed Forces? 15. Was Decedent Ever in U.S. Armed Forces? 16. Was Decedent Ever in U.S. Armed Forces? 16. Was Decedent Ever in U.S. Armed Forces? 17. Was Decedent Ever in U.S. Armed Forces? 18. Was Decedent Ever in U.S. Armed Forces? 19. Was Decedent Ever in U.S. Armed Forces? 19. Was Decedent Ever in U.S. Armed Forces? 10. Was Decedent Ever in U.S. Armed Forces? 10. Was Decedent Ever in U.S. Armed Forces? 11. Was Decedent Ever in U.S. Armed Forces? 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent Ever in U.S. Armed Forces? 14. Was Decedent Ever in U.S. Armed Forces? 15. Was Decedent Ever in U.S. Armed Forces? 16. Was Decedent Ever in U.S. Armed Forces? 16. Was Decedent Ever in U.S. Armed Forces? 17. Was Decedent Ever in U.S. Armed Forces? 18. Was Decedent Ever in U.S. Armed Forces? 18. Was Decedent Ever in U.S. Armed Forces? 19. Was Decedent Ever in U.S. Armed Forces? 19. Was Decedent Ever in U.S. Armed Forces? 19. Was Decedent Ever in U.S. Armed Forces? 19. Was Decedent Ever in U.S. Armed Forces? 19. Was Decedent Ever in U.S. Armed Forces? 19. Was Decedent Ever in U.S. Armed Forces? 19. Was Decedent Ever in U.S. Armed Forces? 19. Was Decedent Ever in U.S. Armed Forces? 19. Was Decedent Ever in U.S. Armed Forces? 19. Was Decedent Ever in U.S. Armed Forces? 19. Was Decedent Ever in U.S. Armed Forces? 19. Was Decedent	t of Hispanic Origin? (Sp. Cuban, Mexican, Puerto No Specify:	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White
	Maryland 21215-0036	ges 1 and 2 should be filed within 72 ho t of Health and Menial Hygiene. If Itam 27 is markad othar than "natur. or othar traumatic event, <u>tre Madical</u>	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 5+ 16a. Decedent's Usual C (Give kind of work of life. DO NOT use of Mechanical	done during most of work retired)	ring	Kind of Business/Industry U.S. Government
	land 2	2 should be filed within and Mental Hygiene. Is marked other then reumatic event, Ire M	To Be Co	17. Father's Name (First, Middle, Last) Dennis Joseph Dunn, Sr.	1	e (First, Middle, Maid (NMN) Wal	-
40/51/11		t 1 and 2 shou Health and N tam 27 is mai	9		Street and Number or Run Brive, Bex		y or Town, State, Zip Code) 3209
11/11	altimore,	Pa Int:		20a. Method of Disposition 1 Dengtion 3 Removal from State 20b. Place of Disposition (Name cemetery, crematory or othe Bel Air Mem. G	Gardens 11-1	18-04	Location - City or Town, State Bel Air, MD
	Balt	permit. Departr Imports any inju		11 W avail 50 W. B		eet, Bel	Air, MD 21014
ENNIS	8760,	value be executed where the partial transit the burial-transit the bur	dical Examiner	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):	f dying, such as cardiac	or respiratory arrest,	Approximate Interval Batween Onset and Death Week S
Q N	O. Box 6	it the death certific by the attending parached for use as f	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregrimment in the past 12 months? 4 □ Pregnant at time of death 5 □ Other (specific pregnant)			23d. Date of delivery Month Day Year
DUN	of Vital Records, P.	Phyalcian: The law requires tha this certificate has been signed ral director, page 2 should be de	To Be Completed by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause Part II. Other significant conditions contributing to death but not resulting in the underlying cause Part II. Other significant conditions contributing to death but not resulting in the underlying cause Part II. Other significant conditions contributing to death but not resulting in the underlying cause Part II. Other significant conditions contributing to death but not resulting in the underlying cause Part II. Other significant conditions contributing to death but not resulting in the underlying cause Part II. Other significant conditions contributing to death but not resulting in the underlying cause Part II. Other significant conditions contributing to death but not resulting in the underlying cause Part II. Other significant conditions contributing to death but not resulting in the underlying cause Part II. Other significant conditions contributing to death but not resulting in the underlying cause Part II. Other significant conditions contributing to death but not resulting in the underlying cause Part II. Other significant conditions contributing to death but not resulting in the underlying cause Part II. Other significant conditions contributing to death but not resulting in the underlying cause Part II. Other significant conditions contributing to death but not resulting in the underlying cause Part II. Other significant conditions contributing to death but not resulting in the underlying cause Part II. Other significant conditions contributing to death but not resulting in the underlying cause Part II. Other significant conditions contributing to death but not resulting in the underlying cause Part II. Other significant conditions contributing to death but not resulting in the underlying cause Part II. Other significant conditions contributing to death but not resulting in the underlying cause cause cause cause cause cause cause cause cause cause cause cause cause cause cause cause	26. Place of Deat Other: 4 Nursing Ho	1 Yes	24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 6 ☐ Other (Specify)
5643	Division	tten deat ctor: / the	Certification:	1 ☑ Natural 5 ☐ Pending (Month, Day Year) Injury 2 ☐ Accident investigation 3 ☐ Suicide 4 ☐ Homicide determined (Month, Day Year) Injury M 28e. Place of Injury - At home, farm, street, factory, or building, etc. (Specify)	1 □ Yes 2 □ No	28f. Location (Street City or Town, St	and Number or Rural Route Number,
¥00 5	-	To the Hospitel or A within 24 hours after To the Funeral Direct completely filled in by	ledical Ce	29a. Certifier (Check only one) 1 Certifying Physicien: To the best of my knowledge, death occurred at the best of my knowledge, death occurred at the best of my knowledge, death			
#		13rl	ate	29b. Signature and title of certifier 29c. L 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month Pay Year) 9 2004 32. Paistrar's Signature	DI9583 Law St	Vor Veet Ma	Date signed (Month, Day, Year) Jember 15,2004 av Jand 21001
		Regist	ıar				

		ı	For State Registrar	State of Marylan		artment of H			giene 004	36689
	Physici		Decedent's Name (First, Middle, Last) Mary	Bernice		Do	rsey	2. Date of De		3. Time of Death
ı	/Medic Examin		4a. Facility Name (If not institution, give s	losputal		4b. City, Town, or	Location of Dea	th	4c. County of De	ath
	Funeral Director		5. Social Security Number 6. Sex 216-24-8091	7. Age (<i>ln yr</i> s.	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hr. Hours Min	. (Month, Da		irthplace (State or Foreign Country) MD
	Maryland I show	tor	10a. State 10b. County MD NA		, Town or Lo					10d. Inside City Limits XXYes 2 □ No
	with the a or 28a Le noti	Direc	10e. Street and Number	Charat		10f. Zip Code	000		10g. Citizen of What	
36	hours after death with the Maryland tural, or Itams 23a or 28a-f show at Examinant be notified at	by Funeral Director	43 South Culver 11. Marital Status 1 Never Married 2 Married 3 X Widowed 4 Divorced	12. Was Decedent Ever in U. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	1	Was Decedent of H f Yes, specify Cuba 1 ☐ Yes 2 No	229 ispanic Origin? (in, Mexican, Pue Specify:	Specify Yes or No nto Rican, etc.)	U • S • A 14. Race - Arr Black, Wi	nerican Indian,
215-0036	n 72	Completed	15. Decedent's Educ (Specify only highest grade	cation	(Give life.	dent's Usual Occup kind of work done of DO NOT use retired	during most of wo f)		16b. Kind of Busines	
7	be filed with tal Hygiene. Id other ther event, tre M	Be Cor	10th grade 17. Father's Name (First, Middle, Last)	NA	Nurs	ing Ass			Nursing Maiden Sumame)	Homes
Maryland	should be nd Mental markad c	ToB	Walter Reddick		481 11 11			Etta Sm		
	1 and 2 s Health ar em 27 ls thar trau		19a. Informant's Name/Relationship (Ty) Charlotte B. Do: 20a. Method of Disposition	rsey-Daught	er 4		Culve		er, City or Town, State Baltin 20c. Location - City o	
Baitimore,	permit, Pages Department of Important: If it any injury or o		1	Ga Ga	rriso		t Vet.	11/24/	04 Owings	s Mills, Mc
	Physician		23a. Part1. Enter the disease, or complishock, or heart failure. List only on Immediate Cause (Final disease or condition	cations that caused the death	1. Do not ent	300 Wab er the mode of dyin	g, such as cardia	ic or respiratory a		Approximate Interval Between Onset and Death
8/60,	Medical Examiner bulkarion and bukician and the burial-transit	dicai Examiner	resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of the consequence of t	uence of):	orcipato	linfa	Monke CUA, F	nolar etoic Coma ZAS	24-36 hrs
O. Box 68	The law requires that the death certifica tie has bein a signed by the attending phage 2 should be detached for use as it	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	3c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of di	death 3	Ectopic pregnancy Other (specify)			23d. Date of d Month	elivery Day Year
rds, P	w requires that be n signed b should be deta	by	Part II. Other significant conditions con	tributing to death but not resu	ulting in the u	nderlying cause give	en in Part I.		obacco use contribute	to the cause of death?
Vital Hecords,		Completed						24a. Was autop perfo 1 Yes	osy prior to rmed? death?	autopsy findings available o completion of cause of us 2 \sum No
	Physician: Th r this certificate ral director, pag	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	ospital: 1 Inpatient 2	ER/Outpatien	t 3 DOA Othe	0.0	ath <i>(Check only</i> o	ne) dence 6 □Other (Sp	acify)
lon of	tanding Phy feath. Ior: After this the funeral o	ation: T	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injun Work	/ at		now injury occurred	osity)
DIVISION	or At after o Dirac in by	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At ho building, etc. (Specify	′)			City or Tow	, 	
	To the Hospital within 24 hours a To the Funaral I completely filled	edical	29a. Certifier 1 ✓ Certifying Phys (Check only one) 2 ☐ Medical Examir	sician: To the best of my kno ner: On the basis of examina and manner stated.	wledge, death tion and/or inv	n occurred at the time vestigation, in my of	ne, date and plac pinion, death occ	e, and due to the ourred at the time,	cause(s) and manner a date and place, and du	as stated. ue to the cause(s)
	To the within 2 To the complet	M	29b. Signature and title of certifier	MEDIUAL RES	IDEN'	29c. License	number		29d. Date signed (Mor	nth, Day, Year)
	10		30. Name and address of person who co	mpleted cause of death (Item	23a) (Type,	Print)			11/17/0	7
	Sta	te.	Muhammad Sa 31. Date filed (Month, Day, Year)	32. Registrar's Signa	152-	c West	and B	IVD, Ba	ltimore in	021227
	Registr	20	MOV 1 0 2004	L. D	1	v .				

36690 State of Maryland / Department of Health and Mental Hygien [] [] 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** XON 7:21 04 largaret /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HOSPItal Baltimore Center N/A 8. Date of Birth (Month, Day, Year) Sept. 18,1922 If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) New York 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Days Months Hours 1 □ M 2 💢 F 18 7675 Director 28 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits ir then "naturel", or Items 23e or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 X No Director Anne Arundel Glen Burnie Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21061 II.S. 404 Irene Drive Funeral filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White þ 3 AWidowed 4 □ Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Importent: If item 27 ie marked other then any injury or other treumetic avant. Elementary/Secondary (0-12) College (1-4or 5+) Packer Glass Company 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Joseph Trembley Emma Tremblay 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 404 Irene Drive Glen Burnie, Maryland 21061 Charles Dixon 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 DBurial 2 Cremation 3 Removal from State MD. State Veteran Cem.11/15/2004 Crownsville, Maryland * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Gonce Funeral Service, P.A. 4001 Ritchie Highway Baltimore, Maryland 21225 23a. Part1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Due to (or as a consequence of): Proysician disease or condition resulting in death) min /Medical Examiner Dreymonie Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last (or as a consequence of) Examiner sician and burial-transit obstructive pulmoney Disease that the death certificate be executed hronic Due to (or as a consequence of) attending physician for use as the buria Division of Vital Records, P.O. Box 68760 Physician/Medical 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Dav in the past 12 months?
1 Yes 2 No 4 Pregnant at time of death 5 Other (specify) ed by the a 9□ Unknown 9 Unknown been signed by Part If. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? res 2. No 2 No 1 Tes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: the Hospitel or Attending 1 Natural 5 Pending investigation after death. 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Thomicide 24 hours a Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated within 2 To the I 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of the san into complete Mause of death (flem 23a) (Type, Print) Hanover 31. Date filed (Month, Day, Year) 32. Registrar's Signature State NOV 1 9 2004 Registrar

State of Maryland / Department of Health and Mental Hygiene 2004 36691 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death NOVEMBER 12, 2004 **Physician FSRIG** 10:15 A M JEANETTE /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MONTGOMERY HEBREW HOME OF GREATER WASHINGTON ROCKVILLE 8. Date of Birth MAY 30, 1910 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 ☐ M 2 🗓 F 94 NY 101-10-6680 Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits or items 23a or 28a-f show other traumatic event, the Madical Examiner must be notified at by Funeral Director SILVER SPRING 1 ☐ Yes 2 No MONTGOMERY 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20906 USA 13824 BLAIR STONE LANE deeth 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-ff Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after I □Yes 2 💢 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 WHITE 1 ☐ Yes 2 💢 No Specify: 3 X Widowed 4 ☐ Divorced "natural" Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene Important: If Item 27 is marked other than 19 any injury or other traumatic access than Elementary/Secondary (0-12) College (1-4or 5+) 12 **PROPRIETOR** PEST CONTROL 17 Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden, Sumame) CAPLAN NIRENBERG ROSE 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MICHAEL ESRIG / SON 13824 BLAIR STONE LANE - SILVER SPRING, MD 20906 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☑ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) 11/18/2004 PINELAWN, L.I., N.Y. NEW MONTEFIORE CEM. e of Funeral Ser 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one pause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 4-Theroscleratic **Physician** Vascular-/Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, learning to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Que to (or as a consequence of) Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed and burial-tran Due to (or as a consequence of): P.O. Box 68760. attending physicien Physician/Medical use as the IF FEMALE: 23c. ff yes, outcome of pregnancy
1□Live birth 2 □ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown been signed be should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. Completed by 3 Probably 4 Donknown 1 ☐ Yes 2 ☐ No Shudwin 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 1 ☐ Yes 2 ☐ No 2 4 No the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Certification: To Be Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ₺ No 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After 5 Pending investigation 1 Natural after death. 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide within 24 hours a To the Funeral D 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only опе) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified Will 1 mD D55258 November 12, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Montrese Road Rockville Waryland B 6121 WIKS GARY 31. Date filed (Mont 9 2004 32. Registrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygien 200 L 36692 For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Year **Physician** JAMES FOGLE SR VERNON NOVEMBER 7, 9:48 A 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner FREDERICK HOSPITAL FREDERICK MEMORIAL FREDERICK If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** 1 X M 2 □ F Yrs. Director 219-03-6378 84 Sept. 8, 1920 Maryland Usual Residence of Decedent with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show ir then "neturel", or items 23e or 28a-f shov It e Wedical Examination will be multiled at 1 ☐ Yes 2 ☑ No Directo Sykesville MD Carroll 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4720 Woodbine Road 21784 United States filed within 72 hours after death Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 11. Marital Status 1 X Yes 2 No 1944— If Yes, Give Year or Dates: 1946 1 Never Married 2 Married 1 ☐ Yes 2 No Specify ģ 3 X Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. int: if item 27 is marked other then ' Elementary/Secondary (0-12) College (1-4or 5+) Electrician Armco Steel or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Oliver H. Fogle Claire Barnes 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Phyllis Gilliss Daughter 4716 Woodbine Road Sykesville, MD 21784 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Nov. 11, permit. Page Department of Importent: If eny injury or once. Lake View Mem. Park 2004 * 4 ☐ Donation 5 ☐ Other (Specify) Sykesville, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility -Queen FuneralHome & Crematory, P.A. Old Liberty Road winfield, MD 21/84 W. Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cruss on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Vascular Cardio Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-transit Tensi 2n and Due to (or as a consequence of) the attending physician Disease Completed by Physician/Medical the 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month Year Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þe 1 ☐ Yes 2 XNo 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 No 24a. Was an has autopsy perform this certificate 2 No 1 Yes 25. Was case referred to medical examiner? Certification: To Be 26. Place of Death (Check only one) Hospital: 2 No Other, 1 Inpatient 1 🗌 Yes 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) completely filled in by the funeral 27. Manner of Death te of Injury 28b. Time of 28d. Describe how injury occurred After (Month, Day or Attending 5 Pending investigation Natural death. 1 Yes 2 No after death Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Sunerel L To the Hospitel Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and or investigation, in my opinion, death occurred at the lime, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29b. Signature an 29d. Date signed (Month, Day, Year) dress of person who co ompleted c use of death (Item 23a) (Type, Print) man-3000251 NINTH ST FREDERICK, MD 21701 31. Date filed (Month, Day, Year) Registrar's Signature State NOV 1 9 2004 Registrar

DHMH 17 Rev 1/200

Baltimore, Maryland 21215-0036

Division of Vital Records. P.O. Box 68760.

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Examiner		4a. Facility Name (If not institution, giv	re street and number)			4b. City, Town, or Location	on of Death		4c. County of		
		University Hospi				Baltimore					
Funeral	-	,	Sex 7.Ag 【IXM 2□F	e (In yrs. last 23	birthday) Yrs.	If Under 1 Year If Und Months Days Hour		B. Date of Birth (Month, Day,	Year)		ace (State or Foreign
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yland iow	-	10a. State 10b. County		10c. City, To	own or Lo	ocation				10	d. Inside City Limits
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2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or Itams 23a or 28a-f show aumatic event, the Medical Evanthat must be notified at To Re Completed by Funeral Director	5	10e. Street and Number				10f. Zip Code		1	0g. Citizen of W	hat Count	ry?
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r Itams 23s	2	11. Marital Status	12. Was Decedent Armed Forces?		13.	Was Decedent of Hispanic If Yes, specify Cuban, Mexi	Origin? (Spec can, Puerto R	ify Yes or No- ican, etc.)		- America , White, e	
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h and 7 is n		19a. Informant's Name/Relationship (Patrice Stewart				ng Address (Street and Num Brookford					
perimit. Fages 1 and 2 should be Department of Health and Menta Important: If item 27 Is marked any injury or other traumatic evonce. To R	-	20a. Method of Disposition	L-MOUNEL	20b. Place	of Dispo	sition (Name of	Da		20c. Location - C		
nt of remit		X Burial 2 ☐ Cremation 3 ☐		ceme	tery, crei	natory or other place) d National			Laurel		
ortani injury	'n	 4 ☐ Donation 5 ☐ Other (Special 21. Signature of Funeral Service Lices 		riat y			1	2/04	naar er	y Mo	
Department of Important: If any injury or once.		Vignath	- K. Inn	1-1	M 4	arch for Fig. 300 Wabash	ëst Ave.	Balti	more.	МД	21215
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Medical		disease or condition resulting in death)		a consequence		naut 10	180			_	
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= =	5	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as	a consequenc	ce of):						
in and ial-transit		Cause (Disease or injury that initiated events resulting in death) Last	c								
physician and sthe burial-transit		rooding in oddin) Edot	Due to (or as	a consequenc	e or):						
physis the		= = =	_ d.							-	
d by the attending phastached for use as the Physician/Med		IF FEMALE:	23c. If yes, outcome	of pregnancy					23d. Date	of dolaron	
o atter of for u	2	23b. Was decedent pregnant in the past 12 months?	1 ☐Live birth 4 ☐ Pregnant at			Ectopic pregnancy Other (specify)			Mont		y Day Year
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igned to be deta	-	Part II. Other significant conditions	contributing to death b	ut not resulting	g in the u	nderlying cause given in Pa	rt J.	23e. Did tob	acco use contrib	ute to the	cause of death?
been sig should b	3 -							1 □ Ye	s 2 No 3	□ Probal	bly 4 ∐Unknown
cate has been so page 2 should								24a. Was ar		ere autops	sy findings available
ste has bage 2	5							autopsy perform 1 Yes 2	ned? da	ath?	pletion of cause of !□ No
is certificate hadirector, page		25. Was case referred to medical examiner?				26. Pla	ace of Death	Check onl one		1.00 2	
this ce al direc)	1 X Yes 2 □ No	Hospital: 1 Inpatie	ent 2X ER/	Outpatien	t 3 DOA Other: 4	Nursing Home	5 🗆 Reside	nce 6 Other	(Specify)	
h. After th funeral	5	27. Manner of Death 1 ☐ Natural 5 ☐ Pending	28a. Date of Inju (Month, D	ry Year) 28b	. Time of Injury	Work?	28	d. Describe ho	w injury occurred	± ,	,
r death. social: so	Can	2 Accident Investigatio 3 Suicide 6 Could not b		04 0	1:09	1	No	5ul	plect	She) T
rs after death. al Diractor: After I led in by the funera Certification:		4 Homicide determined	28e. Place of Inj	c. (Specify)	1	eet, factory, office		f. Location (Str City or Town	eet and Number State) 600	b loc	Route Nymber, ICOT IVVOYEMD
within 24 hours after To tha Funaral Director Completely filled in the Medical Cert		29a. Certifier 1 ☐ Certifying Ph	veician: To the best	11	lae death	occurred at the time, date					
within 24 hours after deatt To the Funeral Director: completely filled in by the Medical Certifical	2	(Check only one)	miner: On the basis of and manner sta	f examination :	and/or in	restigation, in my opinion, d	leath occurred	at the time, da	ite and place, an	d due to to	he cause(s)
Mer		29b. Signature and title of certifier				29c. License numbe	ər	29	d. Date signed (Month, D	ay, Year)
^		Dlarge Ha	Dan M	rd		O.C.M.E	7.	N	iovember	16	2004
18		30. Name and address of person who	completed cause of d	leath (Item 23a	a) (Type,		- •	1,	io verment	1.0,	200T
		CAROLHA	TLANI	nd		Penn Street	, Balt	imore,	Marylan	d 217	201
State	7	31. Date filed (Month, Day, Year)	100	ar's Signature	1	<i>M</i> .			10,000		
Registrar		NOV 1 9 2004	ARRIVES	15.	Good	ge /					

DHMH 17 Rev 1/2001

NOV 1 9 2004

Amend item#23b-c, Print in Black Indelible Ink. First Place Are Legible. State of Maryland / Department of Health and Mental Hygier (1) 36694 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Day Year GLANVILLE EWIS 1355 PM AUGUST 30 /Medical 2004 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Hapkin OhNS n/a If Under 24 Hrs. Year 5. Social Security Number 6. Sex **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months Days M 2□ F Yrs. 83 Director 217-18-1032 Virginia Feb 13, 1921 Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 27 is marked othar than "neturel", or Items 23e or 28a-f show traumatic avent, the Medical Examinar must be notified at 10d. Inside City Limits Seaford Sussex Delaware Director 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with 19973 410 Patriot Street United States by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: White Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) d 2 should be filed within 7. Ih and Mental Hygiene. 7 is marked other then "no Elementary/Secondary (0-12) College (1-4or 5+) Merchant Seaman Shipping 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Glanville Mattie Ishon 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health an 23 Marathon Drive, Seaford, Delaware 19973 Linda Peters / Niece 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Pages nent of h permit. Pages Department of Important: If it any injury or o 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) 9/1/2004 Baltimore, Maryland Bayview Crematory 21. Signatur f Funeral Service Lice 22. Name and Address of Facility Hubbard Funeral Home, Inc. 4107 Wilkens Avenue, Baltimore, Maryland 21229 23a. Part1. Enter the disease, or compilications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ACUTE RIGHT SUBBURAL HEMATOMA Priysician 16 DAYS /Medical Due to (or as a consequence of): Examiner RESPIRATIONS INSAFFICIENCY VATO DAYS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last CERTIFICATION ADDROVED BY MEDICAL EXAMINE Dua to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-transit VASOB-LATORY 4 DAYS and Due to (or as a consequence of) Box 68760 attending physician Physician/Medical the as IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy Por in the past 12 months? 1 ☐ Yes 2 ☐ No Dav Year 4☐Pregnant at time of death 5 ☐ Other (specify) detached Ö the 9 Unknown 9 Unknown à م signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, by pe Femur fracture, Hypertensive atherosclerotic 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗷 Unknown Completed peen cardiovascular disease, atrial fibrillation 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No autopsy performed? 1 Yes 2 No Division of Vital To the Hospital or Attanding Physician: 26. Place of Death Check only one Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred After 1 Atural 5 Pending investigation death 2 Accident August 8, 2004 1 ☐ Yes 2 TNo unk Diractor: Fell out of bed 6 ☐ Could not be 3 🗍 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Nanticoke Memorial 4 | Homicide after Nanticoke Men

12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, Seaford au DB and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 24 hours a 801 Middleford Rd 29a, Certifier Medical (Check only onel 29b. Signature and title of certif 29c. License number 29d. Date signed (Month. Dav. Year) D0061871 MD AUGUIST 30 2004 erson who completed cause of death (Item 23a) (Type, Print) 30. Name an ddress SHIVE NORTH CHARLES STREET, APT 2504 ABHIJIT LELE 218 BALTIMORE MD 21221 31. Date filed (Month, Day, Year)
SEP 0 1 32. Pigistrar's Signature State 2004 Registrar DHMH 17 Rev 1/2001

ORIGINAL

		_ For	State of Ma	ryland	/ Depa	artment of H	ealth a	and M	ental Hy	giene	ogibic.	
		1 - State Registrar			Cer	tificate of L	Death				004	36695
Physici		1. Decedent's Name (First, Middle, Last	•						2. Date of De. Month NOV.	Day 16,	2004	3. Time of Death 16:40 ^M
/Medi Examir		FRANCES GARCZ 4a. Facility Name (If not institution, give				4b. City, Town, or	Location of	of Death	NOV.		ounty of Death	10:40
⁶ Tay	,	JOHNS HOPKINS					IMOR				N/A	
. Funeral Director		216-28-5984	ex 7. Age	(In yrs. las	Yrs.	If Under 1 Year Months Days	ff Under Hours	Min.	8. Date of Bin Month, Da IO/6/	1^{1}	9. Birth	place (State or Foreign NLAND
land DW		Usual Residence of Decedent 10a. State 10b. County		10c. City,	Town or Lo	cation						10d. Inside City Limits
death with the Maryland ms 23s or 28a-f show rmant be notified at	tor	MD N/	A		BALT	TIMORE						1 XYes 2 □ No
or 28	Director	10e. Street and Number				10f. Zip Code				-	n of What Cou	ntry?
eath v	Funeral	4803 GLENARM	AVE.	ver in U.S.	13. V	2120		oin? (Spe	cify Yes or No	US 14	A Race - Americ	can Indian.
after d		1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 🕅 N		1	Vas Decedent of Hi f Yes, specify Cuba I□Yes 2⊠ No	n, Mexican	, Puerto I	Rican, etc.)		Black, White,	
5-UUSO 72 hours after netural; or ita	d by	3 Widowed 4 □ Divorced	If Yes, Give Year or Dates:									ITE
nin 72	plete	15. Decedent's Ed (Specify only highest gra	de completed)		(Give	lent's Usuaf Occupa kind of work done o DO NOT use retired,	lurina mos	t of workii	ng	16b. Kind	of Business/In	dustry
ING Z I Z I 3-UU30 ba filed within 72 hours after death with the Marylan tal Hygiene. d other than "netural", or items 23g or 28a-f show event, tre Medical Exerting from the notified at	Completed	Elementary/Secondary (0-12)	College (1-4or 5-	*)	SI	EAMSTRES	SS			LOND	ON FO	G
	Be	17. Father's Name (First, Middle, Last) STANLEY NIEDZ							(First, Middle, PIETRO		rmame)	
arylar should by nd Menta markad imatic ev	7	19a. Informant's Name/Relationship (19b. Mailin	g Address (Street a					own, State, Zip	Code)
re, Maryla s 1 and 2 should f Health and Mer tem 27 is marks other traumatic		MRS. ROSEMARIE	DOMULEW	ICZ	4226	WESTVIE	W DE			STOW	N, PA	. 17363
0 0		20a. Method of Disposition 1				sition (Name of OF			ate		tion - City or To	
		' 4 □Donation 5 □ Other (Specify 21. Signature of Funeral Service Licer		JEST		EMETERY					ALK, I	MD.
Dep de de de de de de de de de de de de de		1 Eugen	1Cx	5-1		ACZURÓWS 201 DUND						. 21222
		23a. Part1. Enter the disease, or com shock, or heaft failure. List only	one cause on each line	θ.	Do not ente	er the mode of dying	g, such as	cardiac o	r respiratory ar			Approximate Interval Between Onset and Death
Physician /Medical		Immediate Cause (Finaf disease or condition resulting in death)			DIA	LINF	ARC	TIC	N			Oliset and Death
Examiner			Due to (or as a			ARTER	1	ISE	ASE			
-> #	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a	conseque	nce of):	,						
be executed ician and burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. My Due to (or als a	conseque	nce of):	Ion						
ate be executhy sician and the burial-trail	Ical E		d		,							
	g	IF FEMALE:										
BOX 52 Beath certific attending p	Physician/M	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of	2 ☐ Fetal d	eath 3	Ectopic pregnancy				230	I. Date of delive Month	ery Day Year
	yslc	1 □ Yes 2. No 9 □ Unknown	4□Pregnant at t	time or dea:	tn 5L	Other (specify)						
8 5 8 N	by PI	Part II. Other significant conditions of	ontributing to death bu	t not resulti	ing in the ur	nderlying cause give	on in Part I.		23e. Did to	obacco use	contribute lo th	ne cause of death?
w require been sign should b									1 🗆 \	es 2	lo 3 ☐ Prob	ably 4 Unknown
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	e Co	25. Was case referred to medicaf					26 Place	of Death		2. No	1 🗆 Yes	2. No
Or VITA Physicien: this certific ral director,	To B	examiner? 1 ☐ Yes 2 No	Hospital: 1 Inpatier	nt 2 💢 EF	R/Outpatien	t 3□ DOA Othe	ar.		ne 5 Resid		Other (Specifi	y)
E 6 9 9		27. Manner of Death 1 ★Natural 5 □ Pending	28a. Date of Injury (Month, Day	Year) 2	8b. Time of Injury	Work			28d. Describe h	iow injury o	ccurred	
UIVISION i or Attending after death. I Director: Afte	flcat	2 Accident investigation 3 Suicide 6 Could not b	e 28e. Place of Inju	ry - At hom	e, farm, stre		/es 2 □ I				lumber or Rura	l Route Number,
2	Certification:	4 Homicide	building, etc	. (Specify)					City or Tow	m, State)		
To the Hospitei of within 24 hours af To the Funerei D completely filled in	edical	29a. Certifier 1. Certifying Ph (Check only one) 2 Medicel Exer	y sician: To the best o niner: On the basis of and manner stat	examination	edge, death n and/or inv	occurred at the time vestigation, in my or	e, date an pinion, dea	d place, a th occurre	and due to the ded at the time, o	cause(s) an date and pla	d manner as si ace, and due to	ated. the cause(s)
To th withir To th comp	Me	29b. Signature and title of certifier	2-2-			29c. License	number			29d. Date s	igned (Month,	Qay, Year)
		P 0		ath (It. =	12-1/7) J4 ⁻	101			11/1	0100	Γ,
le		30. Name and address of person who	r Avenu	re!	Bal	to M	00	100	H V	mc	enzo	Grapo
St Regist	ate rar	31. Date filed (Month, Day, Year) NOV 1 9 2	2004 32. Regiona	r's Signatui	5	Sport	2					

			1 - For State Registrar	State of Maryland /		nt of Health and te of Death		ne No2004	36696
	Physici		1. Decedent's Name (First, Middle, Las.	VC. CRA	AME		2. Date of Death	Day Year	3. Time of Death 2 200 M
	/Medic Examir		4a. Facility Name (If not institution, give	street and number)		ALT Imop	th e	4c. County of Death	2000
Ì	Funeral Director		5. Social Security Number 6. Se 212-30-0609	x 7. Age (In yrs. last to 72	birthday) If Und Yrs. Months	er 1 Year If Under 24 Hrs Days Hours Min		9. Birthpla Countr 1932 Mary	ce (State or Foreign y) 1and
	e Maryland a-f show	ctor	10a. State 10b. County Maryland N/A		own or Location			100	d. Inside City Limits
	be filed within 72 hours after death with the Maryland lat Hyglene. d other than "naturel", or items 23s or 28s-f show event, its Medical Examinat must be notified at	Funeral Directo	10e. Street and Number 1422 South Charle 11. Marital Status	es Street 12. Was Decedent Ever in U.S.		21230		Citizen of What Countr	
036	ours after d rei', or item Examiner	by	1 Never Married 2 Married 3 Widowed 4 Divorced	Amed Forces? 1 Yes 2 No If Yes, Give Year or Dates: 1951-5	1 □ Yes	edent of Hispanic Origin? (secify Cuban, Mexican, Puer 2 No Specify:	to Rican, etc.)	14. Race - Americal Black, White, et Specify: Whit	c.
9500-5121	within 72 h ene. than "natu te Medical	Completed	15. Decedent's Edi (Specify only highest grad Elementary/Secondary (0-12)		life. DO NOT	ork done during most of wo use retired)	rking 16b.	Kind of Business/Indu	,
Maryland 21		Be	17. Father's Name (First, Middle, Last)		Carpen	18. Mother's Na	me (First, Middle, Maid	en Sumame)	грапу
<u> </u>	should be and Menta marked umatic ev	은	Norman F. 19a. Informant's Name/Relationship (7)	Grahe	9b. Mailing Addres	Cather ss (Street and Number or R		Callahan	ada)
	es 1 and 2 of Health a fitem 27 is r other tre		Brenda L. Jescovit 20a. Method of Disposition 1 Burial 2 Commation 3 DF	ch (Daughter)		th Charles S	treet, Balt		yland 212
Baltimore,	permit. Pag Department Important: I any injury o		* 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licens	Bayvi	ew Crema McCull	nd Address of Facility V-Polyniak F	uneral Home	ltimore, Ma	
<i>y</i>			23a Part1. Enter the disease, or comp shock, or heart failure. List only o	ne cause on each line.	o not enter the mo	de of dying, such as cardia	or respiratory arrest,	ore, Maryla	pproximate nterval Between bnset and Death
ř.	Physician /Medical Examiner		disease or condition resulting in death)	Due to (or as a consequence Due to (or as a consequence Due to (or as a consequence	57 I (MEA	IRT FAIL	LURE	
9760,	death certificate be executed e attending physician and of for use as the burial-transit	lical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence Due to (or as a consequence		, o je			
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7	w requires that the s been signed by the should be detache	by P	Part II. Other significant conditions con	ntributing to death but not resulting	in the underlying	cause given in Part I.	23e. Did tobacco	use contribute to the	cause of death?
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VII	Physician: Th this certificate ral director, pag	o Be	25. Was case referred to medical examiner? 1 Yes 2 6	lospital: 1 ☐ Inpatient 2 ☐ ÉR/O)ta.ati.a.a. 0 0	Other	ith (Check only one)		
ion oi	Jing After fune	ertification; T	27. Manner of Death Natural 5 Pending 2 Accident investigation	28a. Date of Injury 28b.		28c. Injury at Work? 1 Yes 2 No	ome 5 Residence 28d. Describe how inj		
DIVISION	To the Hospital or Attentwithin 24 hours after deatl To the Funeral Director: completely filled in by the	0	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, for building, etc. (Specify)			City or Town, Sta		
	e Hosp 24 hou e Fune letely fi	edical	29a. Certifier 1 Certifying Physical Check only 2 Medicel Examination	sician: To the best of my knowledg ner: On the basis of examination ar and manner stated.	ge, death occurred ind/or investigation	at the time, date and place n, in my opinion, death occu	, and due to the cause(rred at the time, date ar	s) and manner as state nd place, and due to th	d. e cause(s)
	To the within To the complete	Me	29b. Signature and title of certifier			c. License number		ate signed (Month, Day	
	dXI		Lley // L	- MD	لآ	2059076	SIN	OVEMBE	P172504
	2,		30. Name and address of person who co	PARK	Type, Print)	0059076 UB BAL	TIKO	RIS POID	21251
**	Sta Registr		31. Date filed (Month, Dáy, Year)	32. Registrar's Signature	6 Spo	rels			

			for State State Registrar	te of Maryland / D	epa Cert	rtment of F <i>lificate of</i>	lealth and M <i>Death</i>	lental Hygie Reg.		36697
	Physicia		Decedent's Name (First, Middle, Last) FRANK			GAMBEL		2. Date of Death Month NOVEMBER	^{Da} 17, 2 ^Y 804	3. Time of Death 6:20 AM
	/Medic Examin		4a. Facility Name (If not institution, give street	and number)	T		r Location of Death	NOTE:	4c. County of Death	
	LAGITUIT	Ci	BRIGHTON GARDENS AS				PIKESVILL	.E		TIMORE
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last birtl	hday)_	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth	9. Birth	place (State or Foreign intry) MD
	Director		220-07-4639 ¹ X ^{M 2}	□F 84 Y	Yrs.	Days	110010	AUG. 21, 1	.920	MD MD
	and w		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town	or Loc	ation	-			10d. Inside City Limits
	Mary I sho	tor	MD BALTII	MORE			BALTIMORE			1 ☐ Yes 2 No
	r 28a	Director	10e. Street and Number			10f. Zip Code		10g.	Citizen of What Cou	intry?
	th with	al D	8224 MAXINE CIRCLE				21208			USA
	ems	Funeral	An	as Decedent Ever in U.S. med Forces?	13. W	as Decedent of H Yes, specify Cuba	lispanic Origin? (Spean, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Amer Black, White	
36	s afte	by Fu	1 ☐ Never Married 2 🛣 Married 1 ☐ If Ye 3 ☐ Widowed 4 ☐ Divorced Ye	Yes 2 □ No Yes, Give	1	☐ Yes 21X No	Specify:		Specify:	WHITE
8	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or Items 23a or 28a-f show snt, the Medical Examinat must be nutified at	ed b	15. Decedent's Education	ar or Dates:	Decede	ent's Usual Occup	pation	161	b. Kind of Business/li	ndustry
215	nin 72 In "na Medii	plet	(Specify only highest grade comp Elementary/Secondary (0-12) Co	pleted)	(Give k life. D	ind of work done O NOT use retired	during most of works d)	ing		,
7	ad wit	Completed	4	PRO	PRI	ETOR		S	CRAP META	L
Б	be fill stal Hy od oth even	Be	17. Father's Name (First, Middle, Last)	CAN	1BEL		18. Mother's Name	e (First, Middle, Mai	den Sumame)	RUBIN
2	hould d Mer narke	2	I SAAC 19a. Informant's Name/Relationship (Type, Pr.			Addroon (Stroot		A Pouto Number C	ty or Town, State, Zi	
Maryland 21215-0036	d 2 s lth an 27 Is i		HILDA GAMBEL / WIFE		_			BALTIMORE,		_
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be ruitified at once.		20a. Method of Disposition	20b. Place of	Dispos	-			. Location - City or T	
Ë	Page nent o int: If		1 X Burial 2 ☐ Cremation 3 ☐ Remove 4 ☐ Donation 5 ☐ Other (Specify)	u trom State			ISRAEL 11	./18/04	BALTIMOR	E, MD
Baltimore,	permit. Departn Imports any inju		21. Sona ure of Funeral Service Livense.						& BROS.,	
_	20 = 20		Willhard Buy	ju					ESVILLE,	MD 21208
	$-=$ \cdot .		23a. Part1. Enter the disease, or complication shock, or heart failure. List only one day							Approximate Interval Between Onset and Death
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68760,	ificate be executed g physician and as the burial-transit	edical	d							
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ğ	w requires that the death cer been signed by the attendir should be detached for use	by Physician/M	in the past 12 months?	☐Live birth 2 ☐ Fetal death ☐Pregnant at time of death ☐ Unknown		Ectopic pregnancy Other (s <i>pecify</i>)	<u>′ </u>		Month	Day Year
<u>Р</u> О	at the by the	Phys	9 Unknown							
Ś	res th	by	Part II. Other significant conditions contributions	ng to death but not resulting in	the und	derlying cause giv	en in Part I.	23e. Did tobace	co use contribute to	/
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Rec	ne law has l	Completed						24a. Was an autopsy performed	prior to co	opsy findings available ompletion of cause of
a	n: Th	e Co	25. Was case referred to medical				00 Pl/ P	1 ☐ Yes 2 ☑		2 No
5	/sicia s cert directe	To B	examiner?	ıl: 1 ☐ Inpatient 2 ☐ ER/Out	toatient	3□ DOA Oth		n <i>(Check only one)</i> me 5□ Besidence	6 Dother (Speci	MASCICHED
10	g Phy ter thi	n: T	_/	. Date of Injury 28b. Ti		28c. Injur Wor		28d. Describe how in		Living
Sior	endin sath. or: Aff	atlc	2 Accident investigation	(,,	-,,		Yes 2□No			
Division of Vital Record	Hospital or Attending Physician: The law requires that the death cert 24 hours after death. Funeral Director: After this certificate has been signed by the attending tely filled in by the funeral director, page 2 should be detached for use a	Certification:	3 Suicide 6 Could not be determined 286	 Place of Injury - At home, far building, etc. (Specify) 	rm, stre	et, factory, office		28f. Location (Street City or Town, S.	t and Number or Rur tate)	al Route Number,
	pital ours a leral C		29a. Certifier 1 Certifying Physician:	To the best of my knowledge,	death	accurred at the tir	ne, date and place	and due to the cause	a(e) and manner as	
	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	edical	(Check only 2 Medical Examiner: 0	n the basis of examination and manner stated.	d/or inve	estigation, in my o	pinion, death occurr	ed at the time, date	and place, and due t	o the cause(s)
	To the Hospital within 24 hours a To the Funeral Completely filled	Me	29b. Signature and title of certifier	Territor III		29c. Licens			Date signed (Month,	
)	•		Naven & Bal	nt, M.D.		DC	058670	e NC	venber	17,2007
	1)		30. Name and address of person who complete	ed cause of death (Item 23a) (M.D., 75 MO	Type, P	rint)	cuite 20	00000	+(s) ~ · v	MD 2112/
	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's Signature	4			7 17 131	Formi	7.0 21126
	Registr		NOV 1 9 2004	Danier for	9	Sports				
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State of Maryland / Department of Health and Mental Hygiene 2004 36698 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Year Lore E. Hyssong November 2004 9:15 AM /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Glade Valley Nursing Center Walkersville Frederick If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** Year) 1 M 2 XF Months 75 577-52-9952 Director December 23, 1928 Germany Usual Residence of Decedent 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f show event, the Medical Examiner must be notified at 1 TYPYes 2 □ No Director Maryland Frederick Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ŏ or Items 23a 802 Rhine Court Funerai U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black White etc. filed within 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 þ 1 ☐ Yes 2 No Specify: Specify: White 3 X Widowed 4 ☐ Divorced "natural', Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other trainment. Elementary/Secondary (0-12) College (1-4or 5+) Bookkeeper Financial 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 2 Emilie Humme1 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zio Code) Penny Stakes/Niece 6329 Claridge Drive South, Frederick, MD, 21701 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State
1 □ Donation 5 □ Other (Specify) Blue Ridge Memorial Gardens 11/13/2004 Harrisburg, Pennsylvania 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 106 East Church Street Keeney and Basford P.A. Funeral Home Frederick, MD, 21701 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner or Attending Physician: The law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of): the attending physician Box 68760 Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months Month Day Year 5 Other (specify) P.0. 1 ☐ Yes 2 ☐ Yo signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ Completed 2 No 3 Probably 4 Unknown been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 this certificate has autopsy performed? 1 🗌 Yes 2010 ector. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Zursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 No Medical Certification: To 27. Mann of Death 28a. Date of Injury (Month, Day Year) 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Matural 5 Pending death. investigation 1 ☐ Yes 2 ☐ No 2 Accident the within 24 hours after death To the Funeral Director: 6 Could not be determined 3 ☐ Suicide in by t 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide Hospital 1 criffying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the 29b. Signature and Little of certifi-29c. License number ted cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

		State Registrar 1. Decedent's Name (First, Middle, La)	st)	Ce	rtificate of Death	2. Date of Dea	th 2001	4 3669 3. Time of Death
ysicia	ın	Margaret Marie	•			Month	Day Year er 16, 2004	
edica imine		4a. Facility Name (If not institution, giv Stella Maris Ho			4b. City, Town, or Location of D Timonium		4c. County of Dea Baltin	th
ral tor		213-28-0303	Sex 7. Age (In yrs. 7.2 Mg =		If Under 1 Year If Under 24 Months Days Hours M	Hrs. 8. Date of Birth Min. (Month, Day NOV • 21	9. Bin C 1931 Mar	hplace (State or Fore bunity) 'yland
	tor	Usual Residence of Decedent 10a. State 10b. County Maryland Harfor		ty, Town or Lo				10d. Inside City Lim 1 ☐ Yes 2 🔀
TOTAL DELICATION OF THE PARTY O	Director	10e. Street and Number 20 Box Hill Sout	h Parkway. Uni	it 223	10f. Zip Code 21009	1	0g. Citizen of What Co USA	puntry?
event, ins medical examined final contributed at	by Funeral	11. Marital Status 1 □ Never Married 2 ◯ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:	J.S. 13.	Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pr 1 ☐ Yes 2 ☑ No Specify:	? (Specify Yes or No- uerto Rican, etc.)	14. Race - Ame Black, Whit Specify: V	
MedicalE	Completed t	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12)	ducation	(Give	dent's Usual Occupation kind of work done during most of DO NOT use retired)	working	16b. Kind of Business.	
	To Be Con	12 17. Father's Name (First, Middle, Last William Lawrence		Clei	18. Mother's	Name (First, Middle, leed Jane Da	Maiden Surname)	toad
	ř.	19a. Informant's Name/Relationship (Sharon Hennegan/		19b. Maili 1308	ng Address (Street and Number of	r Rural Route Number irt #203, I	r, City or Town, State, 2 Belcamp, MI	Zip Code) 0 21017
any injury or other tr once:	Ì	20a. Method of Disposition 1 Burial 2 To cremation 3 4 Donation 5 Other (Specie	Tuelling at inning grate **		osition (Name of matory or other place) Service Corp 11	Date -17-04	20c. Location - City or	
any inju		21. Sign ur of 500 ral Service Lice		2: N	Name and Address of Facility AcComas Funeral 50 W. Broadway S	Home, P.A. Street, Bel	L Air, MD 2	21014
iner iner-transit	Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Clisease or Wildry that initiated events resulting in death) Last	b. Due to (or as a consect c. Due to (or as a consect consec	quence of):				
tached for use as the b	by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ▼No 9 □ Unknown	d	al death 3[□Ectopic pregnancy □ Other (specify)		23d. Date of del Month	ivery Day Year
		Part II. Other significant conditions	contributing to death but not res	sulting in the u	nderlying cause given in Part I.	1	bacco use contribute to es 2 □ No 3 □ Pr	the cause of death
ral director, page 2 sho	Completed					24a. Was a autops perform	med? prior to death? 2 No 1 □ Yes	topsy findings availa completion of cause 2 \(\text{No} \)
directo	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 🏋 No	Hospital: 1 Inpatient 2	ER/Outpatie	Other	Death (Check only on g Home 5 Reside	ence 6 XOther (Spe	cify) HOSPTC
pletely filled in by the funeral	Certification; T	27. Manner of Death 1 XNatural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	De Blace of loive. At h	28b. Time of Injury	1 28c. Injury at Work? M 1 Yes 2 No	28d. Describe ho	ow injury occurred	
completely filled in by		4 Homicide determined 29a. Certifier 1 Check only 2 Medical Exa	building, etc. (Speci	ify) owledge, deat	h occurred at the time, date and pl vestigation, in my opinion, death o	City or Town	n, State) ause(s) and manner as	stated.
olete	Medical	one)	and nanner stated.	ation and/or ir	29c. License number		9d. Date signed (Mont	
Ē	_	29b. Signature and title of dertifier	/,		D43725		In /	la a a
complet			0 (1, ~		1773/23		11/16	104

DHMH 17 Rev 1/2001

11:15 a.m.

NOVEMBER 16, 2004

MARGARET HENNEGAN

				State of Mar	•	epartme C <i>ertifica</i>				iene ∞. № ՈՐԼ	20700
ı	Physici '/Medic		1. Decedent's Name (First, Middle, Last Robert L	eslie	Humpl	hreys,	Jr.		2. Date of Death	r 17, 200	12:30 AM
Marie .	Examir		4a Facility Name (If not institution, give 1331 Quaker Chu				4	b. City, Town, or L Street	ocation of Death	4c. County of D	
	Funeral Director		5. Social Security Number 6. Se 15 219-56-5542	x 7. Age (In yrs. last birth	Months	er 1 Year Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Feb. 25	9. 1953	Birthplace (State or Foreign Country) Maryland
	anylend show		Usual Residence of Decedent 10a. State 10b. County	1	0c. City, Town	or Location					10d. Inside City Limits
	r 28a-f show	Director	Maryland Harford		Street						1 ☐ Yes 2 No
	with the	Dire	10e. Street and Number			10f. Z	ip Code			og. Citizen of What	
	ter death w	Funeral	1331 Quaker Churc	12. Was Decedent Ev	er in U,S.	13. Was Dec	2115 edent of Hi	/ spanic Origin? (Sp n, Mexican, Puerto			merican Indian,
020	a 9 E	þ	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 ∰ Yes 2 ☐ No If Yes, Give Year or Dates:	1975 1980		ecity Cuba 2lXNo		Hican, etc.)	Black, W Specify:	white
Maryland 21215-0020	n 72 "nat	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)	cation	16a. D		ork done d use retired	ution furing most of work)	sing	16b. Kind of Busine	ss/industry
d 2	filed v Hygie ther t	ပ္ပ	12 17. Father's Name (First, Middle, Last)	/		Attori	ney	18. Mother's Nam	e (First, Middle, N	Law faiden Surname)	
/lan	Aental Aental rked c	To Be	Robert Leslie Hum	phreys, Sr				Rose	9	Bei	d1
Aan	12 should be filed w h and Mental Hygie r is marked other ti traumetic event, In		19a. Informant's Name/Relationship (T)	rpe, Print)	19b. M	Mailing Addra	ss (Street a	and Number or Rur	ral Route Number,	City or Town, State	e, Zip Code)
Baltimore, I	of Healt Item 27		Janice M. Humphre 20a. Method of Disposition 1 □ Burial 2 ▼Cremation 3 □ F		20b. Place of D	1 Quake Disposition (N crematory or	ame of	urch Road	l, Street	MD 21 20c. Location - City	
ţ	permit. Pages Department of I Important: If Ite any Injury or of once.		4 ☐ Donation 5 ☐ Other (Specify)		Bayvie						ore, Maryland
Bal	Depar Impor any fr		21. Signature of Funeral Service Licens	Bria	an T. Cl					Dulaney nium, Mar	Valley, P.A. vland 21093
			23a. Part1 Enter the disease, or composite k, or heart failure. List only o	ications that caused the ne cause on each line.	e death. Do no	ot enter the mo	de of dyin	g, such as cardiac	or respiratory arre	est,	Approximate Interval Between Onset and Death
	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	Adeno	Carcii	noma	0/-	He Pros	state,		2yrs 8mos
	D it	lner		Du	ue to (or as a co	tusta	he i	and re	fractor	1	
0,	icate be executed physician end s the buriel-transit	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Du	ue to (or as a co	ensequence of):		,		
68760,	tificate be execuing physician end as the bunel-train		Cause (Disease of Injury that initiated events resulting in death) Last	Du	e to (or as a co	nsequence of	:				
Box	ath cer tendir or use	lan/N		d							
P.O.	the deay	yslc	Part II. Other significant conditions con	ntributing to death but i	not resulting in t	the underlying	cause give	en in Part I.		1	ute to the cause of death?
	s that gned b	oy P							1 [] Ye	os 2/2 No 3⊡	Probably 4 Unknown
Division of Vital Records,	w requires that the death certifies been signed by the ettending 2 should be detached for use as	Completed by Physician/M							24a. Was ar perform		b. Ware autopsy findings available prior to completion of cause of death?
R	The law ate has t	E O							1 □ Ye	s 2 No	1 ☐ Yes 2 ☐ No
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ou of	To the Hospital or Attending Physician: The law within 24 hours efter death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	on: To	27. Manner of Peath 1 Natural 5 Pending	28a. Date of Injury (Month, Day Y	28b. Tin	me of	28c. Injun Work	4 Li Nursing no	ome 5 Reside 28d. Describe ho	nce 6 Other (S w injury occurred	pecify)
ivisio	or Attending I fler death. Pirector: After in by the fune	edicai Certification:	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury building, etc. (163 2 110	28f. Location (Str City or Town	reet and Number or , State)	Rural Route Number,
	To the Hospital or within 24 hours effet To the Funeral Dir completely filled in	Icai Ce	(Check only 2 Medical Exam)	sician: To the best of r ner: On the basis of ex	amination and/	death occurre or investigation	d at the tim n, in my op	e, date and place, inion, death occur	and due to the ca red at the time, da	use(s) and manner ite and place, and c	as stated. fue to the cause(s)
	ithin 2 o the l	Med	one) 29b. Signature and title of certifier	and manner state	d.	2	9c. License	number	29	d. Date signed (Mo	onth, Day, Year)
	F \$ F 5		XXICO	70	5		D	1297	9	Novemb	xr17,2004
		ŀ	30. Name and address of person who co	Practiva			M 61	CE MD	2123	1	•
	Sta Registr	te ar	31. Date filed (Month, Day, Year)	32. Registrar's	1-,	4	1.				

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend 11 cms 20b c per fh 9837 11-19-04 vt. State of Maryland 7 Department of Health and Mental Hygie 20 0 1 36701 1 - State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month HINTON 9:53 A M KATHLEEN NOVEMBER 2004 10, 4c. County of Death Facility Name (If not institution, give street and number) 4b. City, Town, or laocation of Death stown all 10 an more If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day 6. Sex last birthday Birthplace (State or Foreign
 Country) 5. Social Security Number Days 1 M 20€F 215-03-624 Yrs. Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 1XYes 2 □ No Naryland 10e. Street and Number more 10f. Zip Code 10g. Citizen of What Country? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 XNo Specify: 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) 19a. Informant's Name/Relationship (Type, Print) (niece) 19b. Mailing Address (Street and Number of Rural Route Number, City or Town, State, Zip Code) 11-19-2004 20b. Place of Disposition (Name of Arrive Lugar Mempine Park 20 Ballto City of Jown, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) our 22 Name and Address of Facility 21. Signature of Funeral Service Vicensee Funeral Home 55 Home Joseph Ave. North 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) CONGESTIVE HEART PAILURE Due to (or as a consequence of): ADRTIC STENUSIS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): DISTAGE ARTERY CORDNARY Due to (or as a consequence of): 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 ₩ No 3 Ectopic pregnancy Month Day Year 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an 1 ☐ Yes 2 NO 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 100 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

Physician /Medical Examiner Examiner The law requires that the death certificate be executed tate has been signed by the attending physician and page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760, Hospital or Attending Physician: naral Director: After this certific filled in by the funeral director, death. within 24 hours after deatl To the Funeral Director: completely filled in by the To the

Physician

/Medical

Directo

Funeral

Completed

Examiner

Funeral

Director

? is marked other than "naturat", or ttems 23a or 28a-f show traumatic evant, It e Modical Examinar must be notified at

ges 1 and 2 should be filed within t of Health and Mental Hygiene. If Item 27 is marked other than

injury or othar

permit. Pages 1
Department of H
Important: If ites
any injury or oth

Baltimore, Maryland 21215-0036

Physician/Medical Completed by Be Certification: To

Medical

25. Was case reterred to medical examiner? 1 Tes 27. Manner of Death 1 Natural

29a. Certifier

(Check only one)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier 29c. License number

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

D44505

29d. Date signed (Month, Day, Year)

NOVEMBER 10, 2000

State Registrar

31. Date filed (Month /Day,

IMPERIAL, JR. 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No Decedent's Name (First, Middle, Last) 2. Date of Death Physician Month Day lovember 14,2004 /Medical 4a. Facility Name (If not institution, give street and number 4b. City, Town, or Location of Death 4c. County of D Examiner ITIMOre If Unde Social Security Number 8. Date of Birth (Month, Day, Birthplace (State or Foreign **Funeral** Months Days 214-44-3039 Usual Residence of Decedent 1 M 2□F Director Maruland Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show or other traumatic evant, the Medical Examiner must be notified at Maryland
10e. Street and Number 1 Yes 2 □ No Completed by Funeral Director mor 10f. Zip Code 10g. Citizen of What Country? Itams 23e 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 W No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) American Indian 1 ☐ Never Married 2 Married ō Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. QO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) bore 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Be oma ္ပ Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, (Sister permit. Pages 1 and 2 s
Department of Health ar
Important: If Itam 27 is
eny injury or other trau 400 01 20b. Place of Disposition (Name of 4 ☐ Donation 5 ☐ Other (Specify) .10n 22. Name and Address of E Joseph 2222 W. Nor 21. Signature of Funeral Service Licensee tuneral h Litruss Fu W. North Ave. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, k, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) LURE **Physician** /Medical Due to (or 25)4 **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a or Attanding Physician: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4□Pregnant at time of death 5 Other (specify) P.O. I been signed by the a should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobação use contribute to the cause of death? Division of Vital Records, Certification; To Be Completed by 1 Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed 2 No 2 No 1 Tes 25. Was case referred to medical examiner? 26. Place of Death (Check only one, Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 □ DOA 28a. Date of Injury (Month, Day Year) 27. Manner Death completely filled in by the funeral 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Latural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident within 24 hours after death To the Funeral Diractor: 6 Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) BALI 3

State Registrar 31. Date filed (Month, Day,

32. Registrar's Signature

			For State	State of Maryland	/ Department of F			2001	26700
	Physici	an	1. Decedent's Name (First, Middle,	- 114 11	CIN'S		2. Date of Death Month	Day Year	3. Time of Death
	/Medic	al	4a. Facility Name (If not institution,		4b. City, Town, o	r Location of Ceath	11	4c. County of Dea	7 0 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1
1	Funeral		ANNE ARUN 5. Social Security Number 6	Sex 7. Age (In yrs. last	outen Awar birthday) If Under 1 Year		8. Date of Birth	ANNE 1	thplace (State or Foreign
	Director		216-68-9162 Usual Residence of Decedent	15xm 2□ F 47	Yrs. Months Days	Hours Min.	(Month, Day, Y Dec. 29		aryland
	laryfand ehow	7.	10a. State 10b. County		own or Location				10d. Inside City Limits 1 → Yes 2 → No
	er death with the Maryland Iteme 23a or 28e-f ehow out court be notified at	Funeral Directo	aryland Anne A	rundel Anna	apolis 10f. Zip Code		100	g. Citizen of What Co	
	= 8 ■	eral	1144 Medgar Ex	rers Street 12. Was Decedent Ever in U.S.	214(cify Yes or No-	USA 14. Race - Ame	erican Indian,
36	ੂੰ ਨੂੰ ਬੰ	by Fun	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ※ Novorced	If Yes, Give	13. Was Decedent of H If Yes, specify Cubs 1 ☐ Yes 2 □ No	an', Mexican', Puèrto F Specify:	tican, etc.)	Black, White Specify:	te, etc. Black
5-0036	72 na na		15. Decedent's		6a. Decedent's Usual Occup	during most of workin	g 16	b. Kind of Business	/Industry
2121	S	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	`life. DO NOT use retired Mechan	d)		Automoti	ve
	be filed withintal Hygiene. Ind other therewent, the Meneral Herewent, erewent Herewen	Be	17. Father's Name (First, Middle, La	est)	песнан	18. Mother's Name		iden Sumame)	
Maryland	should be and Menta ie marked eumatic ev	2	19a. Informant's Name/Relationship		19b. Mailing Address (Street		Taylor Route Number, C	City or Town, State, .	Zip Code)
	s 1 and 2 should if Health and Men item 27 is marke other treumatic		Toya Hawkins (8215 Coats1	oridge C		orn Md.	
Baltimore,	0 0		*Y☐Burial 2 ☐ Cremation 3 *4 ☐ Donation 5 ☐ Other (Spe	Removal from State	etery, crematory or other place Ter Hill Cer	netery 11		,	
Balti	permit. Page Department Importent: if any injury o		21. Signature of Funeral Service Lic	ensee		ss of Facility Wm	312)	Colores .	DRTUARY
			23a. Part1. Enter the disease, or co shock, or heart failure. List or	omplications that caused the death. If	Do not enter the mode of dyir		respiratory arres		Approximate Interval Between
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	· CARdiAc	Areythm	iA			Onset and Death
	Examiner		Sequentially list conditions	b. CHRONIC	Reval F	ATTUR	2		years
	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a consequen	me Mellita	15 Tu	100/		years
,092	ite be executed sysician and ne burial-transit		resulting in death) Last	Due to (or as a consequen	nce bf):	c Paul	cpeat	stic	years
68	rtificate ng physi as the	Aedical	TE SELVICE	d. Market	C Culculot	7717	cicaci	. ,	genes
Вох	eath certific attending p	clan/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de 4 ☐ Pregnant at time of death	ath 3 Ectopic pregnancy	1		23d. Date of de Month	livery Day Year
P.O.	res that the de signed by the a I be detached t	Physician/M	1 Yes 2 No 9 Unknown	9 Unknown		i- Davi	22a Did taha	no use contribute to	a the equal of death?
ecords,	w requires that the death certificate been signed by the attending phys should be detached for use as the	by	Part II. Dither significant conditions	s contributing to death but not resultin	ng in the underlying cause giv	en in Part I.	1 Tes	V	o the cause of death? Tobably 4 ①Unknown
Seco	aw Is b	Completed					24a. Was an autopsy performe	24b. Were at prior to death?	utopsy findings available completion of cause of
Vital R	Th ate pag	O	25. Was case referred to medical			26, Place of Death	1 Yes 2 2	No 1 ☐ Yes	No
of Vi	shys this al dii	To B	examiner? 1 Yes No 27 Magner of Death		Outpatient 3 DOA Oth	er: 4 Nursing Hom		e 6 Other (Spe	cify)
Division	Attending F r death. sctor: After by the funer	atlon	1 Natural 5 Pending investigation	(Month, Day Year)	Injury Wor	k? Yes 2 □ No	od. Describe now	injury occurred	
Divis	i or Att	Certification:	3 Suicide 6 Could no 4 Homicide determin		a, farm, street, factory, office	21	8f. Location (Stree City or Town, S	et and Number or Ri State)	ural Route Number,
	To the Hospitel or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the fu	edical C	29a. Certifier (Check only one)	Physicien: To the best of my knowledgeminer: On the basis of examination	edge, death occurred at the tire and/or investigation, in my o	ne, date and place, ar pinion, death occurre	nd due to the caus d at the time, date	se(s) and manner as and place, and due	s stated. to the cause(s)
	To the within 2 To the comple	Med	29b. Signature and title of certifier	and manyfer stated.	29c. Licens	e number	29d	. Date signed (Mont	h, Day, Year)
	7		30 Name and address of across with	Clefant	M) U-C	01856	6 1	1-15-	2004
	0		CHARLES P.	ADAMO UD	ANN	1 polis	Cochrou	21401	1 200
7	Sta Registr	1.65	31. Date filed (Month, Day, Year) NOV 1 9 2	32. Registrar's Signature	& Sparks				

Amend Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.
State of Maryland' Department of Tealth and Mental Hygiene

				State of M	aryrano-/ L	Department of Certificate of			0001	
			Decedent's Name (First, Middle, La	etl		Certificate of	Dealli	Reg	. No.2 0 0 4	36704
-	Physicia	an	1.1.11.	= Jeff		10	Ca	Month /	Dey Year	STarre Oracean T
1	/Medic		4a Facility Name (If not institution, given		762	,	4b. City, Town, of L	ocation of Death	27 Zooc 4c. County of Death	1150700
1	Examin	er	Copper Rio				Sulver	.11	Car	-011
	Funeral		5. Social Security Number 6. 5	Sex 7. A	ge (In yrs. last bir	thday) If Under 1 Yea Months Days	r If Under 24 Hrs.	8 Date of Birth	9 Rirtho	lace (State or Foreign
в	Director		210-20-9013	™ 2□ F 7	7	Yrs. Months Days	Hours Will.	Oct. 7,	1926 M	997
	P .		Usual Residence of Decedent 10a, State 10b, County		10c. City, Tow	n or Location			10	0d. Inside City Limits
	arylar show	5	MD Carrol	1	loc. Ony, Tow	Sykesvill	0		"	1 ☐ Yes 21 No
	28a-1	5	10e. Street and Number	3_	1	10f. Zip Code		100	. Citizen of What Coun	21
	deeth with the Maryland ms 23a or 28a-f show r must be notified at	Funeral Director	710 Obrecht Road				1784	1.09	USA	.,,
	deeth	Jera B	11. Marital Status	12. Was Decedent	Ever in U,S.	13. Was Decedent of If Yes, specify Cul	Hispenic Origin? (Sp	ecify Yes or No-	14. Race - Americ	
0	or the		1) Never Married 2 ☐ Married	Armed Forces? 1x Yes 2 KYes, Give				Hican, etc.)	Black, White,	
21215-0020	hours after urel', or its al Examina	ð Š	3 ☐ Widowed 4 ☐ Divorced	Year or Dates:	WWII	1 ☐ Yes 2 No	эрвску.		Specify: Wh:	Lte
5	neft Contract	Completed	15. Decedent's E (Specify only highest gra	ducation ade completed)	16e.	Decedent's Usual Occu (Give kind of work done life. DO NOT use retin	ipation e during most of work	ing 16	b. Kind of Business/Inc	lustry
7	withir ane. then	E G	Elementary/Secondary (0-12)	College (1-4or	5+)	Self employ			Professiona	a1
	Hygin Hygin	ပိ	17. Father's Name (First, Middle, Last	,			,	e (First, Middle, Ma	iden Sumame)	
an	d be on tel	o Be	William Edwar	d Jeffries	s, Sr.		Marga	aret Buscl	h	
Maryland	ahound Manual Ma		19a. Informant's Name/Relationship (Type, Print)	19b	. Mailing Address (Stree	et and Number or Rur	al Route Number, C	City or Town, State, Zip	Code)
	od 2 27 le	- 1	Mr. William Hopki	n (Nephew)	57	11 French A	venue Syko	esville, l	MD 21784	
ē,	of February 1	- 1	20a. Method of Disposition		20b. Place of cemeter	f Disposition (Name of ry, crematory or other pla athedral Ce	ace)	Date 20	c. Location - City or To	wn, State
Ē	Page net: if iry or	- 1	1 TBurial 2 Cremation 3 C 4 Donation 5 Other (Special		New C	athedral Ce	metery 9,	/27/04 Ba	altimore, N	AD .
Baitimore,	mit. Pa spertmer sportant: y injury		21. Signature of Funeral Service Lice		1	HA CHI TU	NERAL HOMI	E & CHAPE	L, PA (Box	195)
Ш	20 E 2 9		Buan 9.	Harge	T		e, MD 2178			Al
		\neg	23a. Part1. Enter the disease, or comshock, or heart failure. List only	plications that cause one cause on each l	d the death. Do i	not enter the mode of dy	ing, such as cardiac	or respiratory arrest	,	Approximate Interval Between
1	Physician			Hy	pertensi	ive atheros	clerotic o	cardiovaso	cular disea	Onset and Death
	/Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	· tro	9/092	- denerto	-		4	ears
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	ansit	Examiner		b. >27.		consequence of):	-	2 //	16 chin	years
ć	be executed ilclan end burial-trensit	S.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	11	Due to (or es a c	consequence or).	1 he	Du Mi APPROVED BY MEDIC	AL EXAMINE	100 - 5
68760,	ficate be ex physician es tha burial	edicai	Cause (Disease or injury that initiated events resulting in death) Last	c. 14/	Due to (or as a	consequence of):	CERTIFICATION	APPROVED		rew >
			resulting in death) Last	,			CEIVIII.		i i	
Box	th ce thendl or use	<u></u>		d						
	requires that the death cert een signed by the attendin hould be detached for use	Completed by Physician/N	Part II. Other significant conditions of	ontributing to death b	ut not resulting in	the underlying cause g	iven in Part I.	23b. Did toba	cco use contribute to	the cause of death?
P.O.	hat the sed by detac	£	Dixbetec well	this G	ulder	I heart	2-61	1 ☐ Yes	2□No 3□ Prob	ably 4 ☐ Unknown
Vital Records,	signe d be	اھ	Dementia, seizur	e disorde	T . /			24a. Was en a	uutonsv 24b We	re autopsy findings
ပ္ပ	w require	e	gastroogophogy	al fe	top d	175 ac		performed	d? ava	ilable prior to
Re	The law ste hes b pege 2 s	E	1 1 1					4 🗆 V		leeth?
ā	icien: The lav certificate has rector, page 2		25. Was case referred to medical			· · · · · · · · · · · · · · · · · · ·	26 Place of Door	1 ☐ Yes h (Check only one)	2 NO 1	IYes 2□ No
>	Physicien: The lithis certificate he rail director, pege	To Be	examiner? 1 To Yes 2 → 140	Hospital:	ent 2 ER/Qu	tpetient 3 DOA	thor:		e 6 □Other (Specify)
0	g Phys er this neral di	Ë	27. Manner of Death	28a. Date of tnju (Month, Da	ry 28b. 1	Time of 28c. Injury Wo		28d. Describe how		
Ö	Attending or deeth.	ate	16 Accident 5 ☐ Pending investigation	August 1		14 4F		Probable	fall	
Division of	r Atterder de recto	≗	3 Suicide 6 Could not b	28e. Place of Inj		rm, street, factory, office	1	28f. Location (Stree City or Town, S	et and Number or Rural State) Copper	Route Number,
	ital or rel Dir led in	3		nursi	ng home			Nursing H	iome, 710 0	brecht Kd.
	Hospital 24 hours Funerel itely filled	edicai Certification:	29a. Certifier 1 ☐ Certifying Ph (Check only 2 ☐ Medical Exar	niner: On the basis o	f examination en	, death occurred at the t d/or investigation, in my	ime, date and place, opinion, death occurr	and due to the caus red at the time, date	ob(s) and thanner as stand and place, and due to	ated. the cause(s)
			29b. Signature and title of certifier	end manner st	otou.	29c. Licen	se number	29d.	Date signed (Month, L	Dey, Year)
	- s - ó		1/1/1/1	111_	410	m	EG12 -		g/zestan	
		-	30. Name and address of person who	completed cause of c	leath (Item 23a) ((Type, Print)	70197		1101100	
	1)		Willer Kus	295 Sto	ner A.		97 Wes	stningte	of MD	21157
	Stat	е	31. Date filed (Month, Day, Year)	32. Registr	er's Signature	1 .				
	Registra	ar	MANT (()	104 100	end	M las	1.			

unkno 04-72 DOS	wn 04-3 261	604	For State Registrar	State of Man	-	Department of Certificate of	Health and M	, ,	ene	
•	Physici /Medio Examin	al	Decedent's Name (First, Middle, L. CHRISTOPHER M 4a. Facility Name (If not institution, given the second of the sec	ICHAEL JEL	EN.	4b. City, Town Baltim	, or Location of Death	2. Date of Death Month November	Day Year	ਤੀ ਜ਼ਿੰਗ ਹੈ ਹੈ ਹੈ 900 a ^M
	Funeral Director		Social Security Number 6.		n yrs. last bin		r If Under 24 Hrs.	8. Date of Birth (Month, Day, Y		place (State or Foreign Intry) ZLAND
	the Maryland 28a-f show polified at	ector	10a. State 10b. County MD HARFO 10e. Street and Number		0c. City, Town	JOPPA		100		10d. Inside City Limits 1 ☐ Yes 2 No
	h with	ai Dir	76 HAVERHILL	RD.		210		100	J. Citizen of What Cou USA	ntry?
920	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturel', or items 23e or 28a-1 show any injury or other treumatic event, the Mardical Example at multile notified at once.	by Funeral Director	11. Marital Status 1 Nover Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Eve Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	er in U.S.	13. Was Decedent of If Yes, specify Cu	Hispanic Origin? (Speuban, Mexican, Puerto o Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ameri Black, White, Specify:	
Baltimore, Maryland 21215-0036	filed within 72 ho Hygiene. other then "netur ent, Tre Necical	Completed	15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12)	Education rade completed) College (1-4or 5+)			upation le during most of worki red) OPERATOR	ng	b. Kind of Business/Ir	•
yland 2	should be filed vand Mental Hygies marked other toumstice event, III	To Be Co	17. Father's Name (First, Middle, Las ROBERT JELEN	, SR.			18. Mother's Name	(First, Middle, Ma	iden Sumame)	
Mar	nd 2 shallth and 27 is m		19a. Informant's Name/Relationship MR.&MRS. ROBER			Mailing Address (Street	et and Number or Rura	PPA, MI		o Code)
lore,	ges 1 and 2 it of Health if item 27 or other tre		20a. Method of Disposition 1 ☐ Burial 2 爲 Cremation 3 [☐Removal from State		Disposition (Name of y, crematory or other p			c. Location - City or T	own, State
Baltin	permit. Pag Department Important: I any injury o		'4 □Donation 5 □ Other (Spec 21. Signature of Funeral Service Lie	••	BAYVI	RACZORO	TORY: 11/1 WSKT: FUNE NDALK AVE	ERAL HOM	IE P.A.	
	Physician /Medical Examiner private personner private	dlcai Examiner	23a. Pant1. Enter the disease, or consider the disease, or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Dvow M. Due to (or as a co	onsequence of	omplications	kd by No	wotc I	ntoxication	Approximate Interval Between Onset and Death
Division of Vital Records, P.O. Box 68	To the Hospitel or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death. To the Funerel Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit.	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	23c. If yes, outcome of p 1 □ Live birth 2 □ 4 □ Pregnant at tim 9 □ Unknown	Fetal death	3 ☐ Ectopic pregnan 5 ☐ Other (specify)	су		23d. Date of delive	ery Day Year
rds, P.	w requires that been signed by should be deta	by	Part II. Other significant conditions	contributing to death but n	ot resulting in	the underlying cause g	given in Part I.	ii .	cco use contribute to the	12'
al Reco	nding Physicien: The law re th: After this certificate has be s funeral director, page 2 sho	Completed						24a. Was an autopsy performer 1 Yes 2	prior to co d? death?	opsy findings available impletion of cause of
Vita	ysicien s certifi director	o Be	25. Was case referred to medical examiner? 13☑ Yes 2 ☐ No	Hospital:	2 ∏ EB/Out	patient 3 DOA	26. Place of Death		e 🗖 Other (Specif	wat scene
n of	ing Phy After thi uneral o	Ion: T	27. Manner of Death 1 □Natural 5 □ Pending	28a. Date of Injury (Mo th, Day Ye	28b. T	ime of 28c. Inj	ury at 2	8d. Describe how	injury occurred	y at scare
Divisio	el or Attend s after death of Director: /	Certification:	2 Accident investigation 3 Suicide 6 Could not learning	28e. Place of Injury	- At home, far Specify)	m, street, factory, office			0007	al Route Nymber, Carolin & ST
	To the Hospitel or At within 24 hours after or to the Funerel Directompletely filled in by	edical (29a. Certifier (Check only one) 1 ☐ Certifying P 2 ☐ Medical Exa	hysician: To the best of m miner: On the basis of exa and manner stated	ny knowledge, amination and	death occurred at the	time, date and place, a	and due to the caused at the time, date	a(s) and manner as s	tated
	To the within To the comple	Med	29b. Signature and title of certifier	1/ 0	m	29c. Licer	nse number		Date signed (Month, ovember 10	
_	Ź		30. Name and address of person who	WALRED		Type, Print) 111 I	Penn Street	, Baltim	ore, Maryl	and 21201
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's	Signature	4 1				

	1	Amend item 234			Certificate of	Death	Reg.	No. 2004	36706
Physician		. Decedent's Name (First, Middle, L	ast)					Day Year	J OS PM
/Medical		a. Facility Name (If not institution, gi	ve street and number)		4b. City, Town,	or Location of Death	June	4c. County of Death	1
Examiner		Union Memori	0 . /	tal		timure		N/a	
Funeral	5	. Social Security Number 6.	Sex 7. Ag	e (In yrs. last b	irthday) If Under 1 Year Months Days		Date of Birth (Month, Day, Ye	9. Birth	nplace (State or Foreign
Director		237 18 2601	1□M 2DF	80	Yrs.	Tiodis Milli	mucry 27		l.e
≥ 1122	-	Jsual Residence of Decedent 10a. State 10b. County		10c. City. Toy	vn or Location				10d. Inside City Limits
ene. than "natural, or itams 23a or 28a-f show re Madical Examinar must be redified at monitored by Finneral Director	- 1	MD N/			HIMURE				1 √es 2 No
a or 28a-f s be rivillied Director	į .	0e. Street and Number		104	10f. Zip Code		10g.	Citizen of What Co	untry?
Sa or	5		e Street	sof 10	12 2121	3		U.S.A.	
al', or Itams 23a or 28a-f shoi Examinat must be indiffed at the Funeral Director	2	1. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S.	13. Was Decedent of	Hispanic Origin? (Specifoan, Mexican, Puerto Ric	y Yes or No-	14. Race - Amer Black, White	
or Ita	3	1 Never Married 2 Married		No	1 ☐ Yes 2 € No		an, 610.)		
	<u>ב</u>	3 Widowed 4 □ Divorced	Year or Dates:		/-			1-	Plack
her than "natural", it, the Medical Era		15. Decedent's (Specify only highest of	Education rade completed)	16	a. Decedent's Usual Occu (Give kind of work done life. DO NDT use retin	during most of working	168	o. Kind of Business/I	ndustry
Important: If itam 27 is marked other than any injury or other traumatic avant, Ital Magnes. To Be Commit		Elementary/Secondary (0-12)	College (1-4or	5+)	INKnown	,		Unknown	J
1 2	3	17. Father's Name (First, Middle, La	st)		arakino-1-	18. Mother's Name (F	First, Middle, Mai		
c avan	ă		Ason			Sula R	755		
other traumatic avant, the Mudical	2	19a. Informant's Name/Relationship		19	b. Mailing Address (Stree			ity or Town, State, Z	lip Code)
rtrau		Theima Joyner		1	134 N. Buno	1 St Back	make MD	21213	
othe		20a. Method of Disposition		20b. Place	of Disposition (Name of ery, crematory or other pl		200	c. Location - City or	Town, State
y or		1 M Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Special Control C			butus Memu		/	Bastimons.	MD
any injury ODCE.		21. Signature of Funeral Service Lic		, ,,,	22. Name and Add	ess of Facility 3 8		el Home	, .
any ir		Vatuela 1	Buts		1129 N. C	ARRIVE ST 1	BA Himur	18 MD 213	213
		23a. Part1. Enfer the disease, or co shock, or heart failure. List on	mplications that cause	d the death. Do	not enter the mode of dy	ing, such as cardiac or r	espiratory arrest		Approximate Interval Between
ician		Immediate Cause (Final	Road Road	нуре	rtensive atl	eroscierot	— dise		Onset and Death
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	Ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying		a consequenc	e of):				1/4 0 0
Iransi	Examiner	that initiated events	c	120					10 year
73 -		resulting in death) Last	Due to (or as	a consequenc	fra L.	-0	,	EV MEDICAL EXAMINATION DATE OF delicements of delicements of the second delicements of the secon	Jana Carl
			La	ПР	Trana	1	I de	EX MEDICAL EXTEN	mont
e as	Physician/Medica	IF FEMALE:	000 14			7	CATION APPROVE	DRIME	
for us	an	23b. Was decedent pregnant in the past 12 months?		2 ☐ Fetal dea at time of death		ch CEKIII.		Month	very Day Year
tached f	SIC	1 ☐ Yes 2 D No 9 ☐ Unknown	9□ Unknown	it time of death	5 🗌 Other (specify)				
		Part II. Other significant conditions	contributing to death	but not resulting	in the underlying cause of	ıven in Part I.	23e. Did tobac	 co use contribute to	the cause of death?
5 8 3	2	Acute renal in					1 Yes	2 □ No 3 □ Pr	obably 4 DUnknown
should	ete			<i>,</i>			24a. Was an	24h Were au	topsy findings available
5 64 1	ompieted	Remote hip	tracture				autopsy performe	prior to death?	completion of cause of
4 0 (ပ ု						1 ☐ Yes 24	No 1 ☐ Yes	2) No
6 5 G	Re	25. Was case referred to medical examiner?	Hospital:		25 204 0	26. Place of Death /		- 0 D0than (0-a)	-14.0
E E	0	Yes 27 No	1 Dinpat 28a. Dalle of Inj	urv 28b	Outpatient 3 DOA Time of 28c. Injury	4 U Notising Home	d. Describe how	e 6 Other (Specinjury occurred	ary)
funer		1 Natural 5 Pending investiga	ion April 2	11			Subject	foll	
by the	1ica	3 Suicide 6 Could no	be 28e. Place of Ir	njury - At home,	farm, street, factory, office	1	Location (Stree	et and Number or Ru	ral Route Number,
d in b	Certification;	4 Homicide	home	etc."(Specify)		14	OI E. O	liver St.	, Apt 102
		29a. Certifier 1 Certifying	Physician: To the bes	t of my knowled	ge, death occurred at the	time, date and place, an	t timore	se(s) and manner as	stated.
	<u>.</u>	one)	and manner s	tated.	and/or investigation, in my				
oletely fille	8				29c. Lice	nse number	29d	Date signed (Monti	h, Day, Year)
To the Funeral Dir	Medicai	29b. Signature and title of certifier							
completely fille	Med	29b. Signature and title of certifier	mD,		ν	055057		une 2	4,2004
To the Funera	Med	29b. Signature and title of certifier 30. Name and address of person with	mb,	death (Item 23a	(Type, Print)	05505		une 2	4,2004 h. 1
within 24 hours after of To tha Funeral Diracl completely filled in by	Med	30. Name and address of person with the compact of	mb, no completed cause of um'en 32. Regis	death (Item 23a	(Type, Print) nial Hos	pital, 201	E, uni	versity	Mark way

			1 - For Stete Registrar	State of Maryla		artment of H			Reg. No.	04	36707
	Physicia	an	Decedent's Name (First, Middle, Last) Bruce Johnson					2. Date of De Month	Day	Year	3. Time of Death
*	/Medic	al	4a. Facility Name (If not institution, give s	tract and aumber!		4b. City, Town, or	L coation of C	Novemb	er 12	2004	8:00P M
	Examin	er	1275 Sheridan Ro	•		Crowns	ville		Anne	Aru	
e E _{god} o	Funeral Director		218-58-6316	7. Age (In y.	rs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hours	Min. 8. Date of Bir (Month, Date of Bir (Month, Date of Bir	y, Year)	Cour	place (State or Foreign otry) yland
	and and		Usual Residence of Decedent 10a. State 10b. County	10c.	City, Town or Lo	cation				1	0d. Inside City Limits
	Mary fied	tor	Maryland Anne Ar	undol Cr	ownsvi	110					17∑Yes 2 No
	r 28e	Directo	10e. Street and Number	under Cr	OWIISVI	10f. Zip Code	****		10g. Citizen of \	What Cour	ntry?
	h witt		1275 Sheridan R	oad		2103	2			USA	
	deat deat	Funeral	11. Marital Status	12. Was Decedent Ever in Armed Forces?	U.S. 13.	Was Decedent of H f Yes, specify Cuba	ispanic Origin	? (Specify Yes or No)- 14. Rac	e - Americ	can Indian,
9	filed within 72 hours after death with the Maryland Hygione. Hysione. Insturati, or Items 23a or 28e-f show wit, the Marical Examinating motified.	by Fu	1 Never Married	1 ☐ Yes 2 XNo If Yes, Give			Specify:	, , , , , , , , , , , , , , , , , , , ,	Specify		lack
2-0036	hour tural		3 Widowed 4 Divorced	Year or Dates:	16a Dece	dent's Usual Occup	ation		16b. Kind of B		
<u>.</u>	in 72 n "na Astic	plet	(Specify only highest grade	completed)	(Give	kind of work done of DO NOT use retired	during most of	f working			Food
7	d with giene or the	Completed	Elementary/Secondary (0-12) 12th	College (1-4or 5+) 3 yrs.		Clerk			Ware	-	
2	al Hy al Hy I othe vent,	Bec	17. Father's Name (First, Middle, Last)				18. Mother's	Name (First, Middle	, Maiden Suman	18)	
yland	Ment Ment arkec	10	Harrison Jo					net Matt			
Mar	12 sh h and 7 le m treum		19a. Informant's Name/Relationship (Ty) Janet Johnson (· · · · · · · · · · · · · · · · · · ·		_		or Rural Route Numb Crowns			
a)	1 and Healt Healt tem 2		20a. Method of Disposition		. Place of Dispo	sition (Name of		Date	20c. Location -		
Saltimor	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If term 27 is marked other than "natural; or Items 23a or 28e-f show any injury or other treumatic avent, the Medical Examine must be notified at once.		1 ☐Burial 2 ☐Cremation 3 ☐R 14 ☐Donation 5 ☐ Other (Specify)	emoval from State		natory or other place t Cemet	ery :	11/18/04			
	partme porter injur		21. Signature of Funeral Service License	90		. Name and Addres					
ñ	Depa Impo		Larry DiRe	seM0048	3 8	m. Rees 21 West	e & So St.	ons Mort Annapoli	uary, I s, Md.	214	01
			23a. Part1. Enter the disease, or compli shock, or heart failure. List only or	cations that caused the de e cause on each line.	eath. Do not ent	er the mode of dyin	g, such as car	rdiac or respiratory a	rrest,		Approximate Interval Between
, 1	Pnysician		Immediate Cause (Final disease or condition	Dila	ted	Card	iny	Satter			Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a cons	sequence of):	11	1,1	platty			
	***	-	Sequentially list conditions,	Due to (or s a cons	FUS-V	c He	ort	Disca	80	-	
	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	, Moss	,						
ב. ב	be executed Ician and burial-transit	Еха	that initiated events resulting in death) Last	Due to (or as a cons	equence of):						
2/pn	cate be executed physician and the burial-transit	dlcal									
0	entifica ling ph e as t	Med	IF FEMALE:	2. 16							
ž Pox	w requires that the death certifi been signed by the attending should be detached for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of pred 1 ☐ Live birth 2 ☐ F	etal death 3	Ectopic pregnancy			23d. Dat Mo	te of delive nth	ory Day Year
	the de	yslc	1 Yes 2 No	4☐ Pregnant at time of 9☐ Unknown	ordeath 5L	Other (specify)					
7	that	by Ph	Part II. Other significant conditions cor	tributing to death but not	resulting in the u	nderlying cause give	en in Part I.	23e. Did t	obacco use cont	ribute to th	ne cause of death?
202	law requires that as been signed b 2 should be deta							10	Yes 2 No	3 🗌 Prob	ably 4 Unknown
Records,	aw re	Completed						24a. Was		Were auto	psy findings available
ř	sicien: The law s certificate has b lirector, page 2 s	Com						perfo	rmed?	death?	
Mai	Physicien: this certific ral director,	Be (25. Was case referred to medical examiner?					Death (Check only of	one)		
0	shysi this c	ို	1 195 23010		☐ ER/Outpatien		4 Nursi	ng Home 5 Resi			()
	ting Phys	lon	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year) 28b. Time of Injury	Worl	γατ k? Yes 2⊡No		how injury occurr	өа	
DIVISION	Attender death	Certification;	3 Suicide 6 Could not be	28e. Place of Injury - A	t home, farm, str			28f. Location (Street and Numb	er or Rura	I Route Number,
5	el or /	Serti	4 Homicide determined	building, etc. (Spe				City or To	wn, State)		
	To the Hospitel or Attending Physicien: within 24 hours after deals. To the Funerel Director: After this certification the funeral director, the funeral director, sompletely filled in by the funeral director,	edical (29a. Certifier 1 Certifying Phys (Check only one) 2 Medical Examin	sicien: To the best of my inter: On the basis of exame and manner stated.	ination and/or in	continution in my	ninian danth.	and a contract of the same	data and alasa.		the entree (-)
	To the within To the comp	Me	29b. Signature and title of certifier			29c. License	number	1.	29d. Date signed	d (Month,	Day, Year)
		4				036	38	4	11/16	5/09	4
	3		30. Name and address of person who co	mpleted cause of death (I	tem 23a) (Type. 7 8 4 5	OAKWOO	D R	4 Good, GUA	N BUN	eni	E, ND
H	Sta Registr		31. Date filed (Month, Day, Year)	32. Abgistrar's Si	gnature &	Sporks	/				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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,	1.	Dece
hysician /Medical	ı	J
/ INICOICAL	40	Fooi

Examiner

Funeral Director

the Maryland rel', or items 23e or 28e-f show Exeminary ust be notified at death with Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. "neturel" other then "netur Is marked

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

If item 27

permit. Page Department of Importent: If eny injury or once.

attending physician the the been signed by has this the

Inecurus, P.O. Box 68760, A Hospitel or Attending Physicien: Director: After within 24 hours a To the Funeral C

Division of Vital Records, P.O. Box 68760.

Certificate of Death 0013 2. Date of Death dent's Name (First, Middle, Last) NO MORTH BERDAY B. EXPANS OSEPH S. KOTERWAS 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | Min. | 7 / 9 / 2 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex 9. Birthplace (State or Foreign 1XM 2□F MĂRŸLAND 216-12-9545 81 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 ☐ Yes 2 No Director MD ANNE ARUNDEL GLEN BURNIE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21060 7678 MUELLER DRIVE USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 ☐ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status Black, White, etc. 1 □ Never Married 2 □ Married 1 ☐ Yes 2 ☑ No Specify: by Specify: 3 ₩ Widowed 4 Divorced Year or Dates: WW II WHITE Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) BALTIMORE COUNTY 12 4 TEACHER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be VINCENT KOTERWAS ANTOINETTE BLUSIEWICZ 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 715 MAIDEN CHOICE LN. BALTIMORE, MD. MR. WALTER KOTERWAS 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c Location - City or Town State 1 Burial 2 □ Cremation 3 □ Removal from State 11/22/04 STANISLAUS BALTIMORE, MD. `4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee RACZOROWSKI FUNERAL HOME P.A. 11201 DUNDALK AVE. BALTIMORE, MD. 21222 23a. Part1. Enter the dise e, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or ach line. Approximate Interval Between Onset and Death YEHKO Immediate Cause (Final SEVERE CORONARY ARTERY DISEASE disease or condition resulting in death) Due to (or as a consequence of): END STAGE RENAL DISEASE ON HEMODIALYSIS YEARS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner ATRIAL FIBRILLATION ON COUMADIN YEARS that initiated events resulting in death) Last Due to (or as a consequence of): ENCEPHALOPATHY SUPERIMOSED ON DAYS by Physician/Medical OLD CEREBROVASCULAR DISEASE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy Month Day Year in the past 12 months? 4☐ Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? SICK SINUS SYNDROME 1 Yes 2 No 3 Probably 4 Nnknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes No STATUS POST PACEMAKER PLACEMENT 24a. Was an autopsy perform 2 No 1□ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) No No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient P 1 Tes 2 ER/Outpatient 3 DOA Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification; 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1x Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier 29c. License number DØØ25886 8-2004 ralls 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar DHMH 17 Rev 1/2001

State

LILIA CEBALLOS M.D.

NOV'I 9 2004

31. Date filed (Month, Day, Year)

OSLER DRIVE TOWSON, MARYLAND 21204

7601

32. Registrar's Signature

			For State Registrar	State	of Maryland	i / Depa <i>Cei</i>	artment of <i>rtificate o</i>	f Health and If Death	i Mental Hy	/gier 12e () Reg. No.	04	36709
			1. Decedent's Name (First, M	liddle, Last)					2. Date of D Month	eath Day		3. Time of Death
	Physici /Medi		Betty Esther	Kahanowitz						er 17,	Year 2004	1:31 am M
	Examir		4a. Facility Name (If not instit		,		4b. City, Town	n, or Location of De	ath		unty of Death	
			Gilchrist Ce				If the dead No.	Towson			timore	
	Funeral Director		5. Social Security Number 088-05-1559	6. Sex 1 □ M 2 F	7. Age (In yrs. la	ost birthday) 0 Yrs.	Months Day			av. Year)	9. Birth Coul Pola	place (State or Foreign ntry) and
	pur *		Usual Residence of Decedent 10a. State 10b. Co.		10c City	Town or Lo	ncation					10d. Inside City Limits
_	Aaryli F sho	ō		timore	Tow							1 □Yes 2 No
$\overline{\omega}$	the N	Director	10e. Street and Number	CIMOIC	100	3011	10f. Zip Cod	Α		10g Citizen	of What Cou	
0	Sa or		615 Chestnut	Avenue			21204				d Stat	
	ms 2	Funeral	11. Marital Status	12. Was De	cedent Ever in U.S	i. 13.	Was Decedent of	of Hispanic Origin? uban, Mexican, Pue	(Specify Yes or N	0- 14.	Race - Americ	can Indian,
36	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. It has the marked other than "natural", or items 23a or 28a-f show titem 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examinations be notified at	P	1 ☐ Never Married 2 ☐ 3 ☑ Widowed 4 ☐ Divo		2 No		1 Yes, specify C		erto Rican, etc.)	1	Black, White, ec <i>ity:</i> White	
ğ	2 hou	ted	15. Dece	dent's Education		16a. Deced	dent's Usual Oc	cupation		16b. Kind d	of Business/In	dustry
Maryland 21215-0036	within 73 ene. than "n	Completed	Elementary/Secondary (0-	ghest grade completed (2) College	(1-4or 5+)	(Give life.	kind of work do: DO NOT use ret	ne during most of w ired)	vorking	Insur		,
21	filed withi Hygiene. other than ent, the M	Co	12			Secre	tary					
and	should be filed and Mental Hygid Is marked other aumatic event, II	Be	17. Father's Name (First, Mid Sam Schmara						_{ame (First, Middle} Janesky	, Maiden Sur	name)	
ž	should be nd Mental marked c	J.	19a. Informant's Name/Relat			10h Mailin	a Address (Stra	eet and Number or		or City or To	um Ctata Zia	Code
Ma	od 2 s Ith an 27 Is I		Mrs. Rosalie		ughter			nt Road,				Code)
ē,	s 1 and 3 f Health item 27 other tra		20a. Method of Disposition		20b. Pla	ace of Dispo	sition (Name of	1	Date		on - City or To	own, State
D E			1 ☐ Burial 2 ☐ Cremat 1 ☐ Donation 5 ☐ Othe	ion 3 □Removal fron er <i>(Specify)</i>	n State	-	natory or other p ke Crem	· 1	Oct 21 2004	Beltsv	ville,	MD
Baltimore,	permit. Pages 1 ar Department of Hea Important: If item any injury or othe		21. Signature of Funeral Sen	rice in ensee Komman	M0038			dress of Facility On and Fu een Pastu			ives timore	, MD
	- 11		23a. Part1. Enter the disease shock, or heart failure.	e, or complications that	caused the death.	Do not ent	er the mode of o	tying, such as cardi	ac or respiratory a	rrest,	*	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	List only one oddoo on	richt	14:	1 Fr	acture				
	/Medical		resulting in death)	aDue to	o (or as a conseque	ence of):	P	CERTIFICATION		11	1	2
п	Examiner	_	Sequentially list conditions,	b				1	u	ILT	7	
	ed isit	Examiner	if any, leading to immediate cause. Enter University Cause (Disease or injury	Due to	o (or as a conseque	ence of):		The	OVED BY MED	ICAL COLOR		
•	xecut and	xan	that initiated events resulting in death) Last	c	o (or as a conseque	ence of):		PERTIFICATION	APPROVE			
68760,	ificate be executed g physician and as the burial-transit					,		OBILL				
89	ifficate g phy as the	edical		U								
Вох	attending for use a	M/u	IF FEMALE: 23b. Was decedent pregnant		utcome of pregnan		Estable program	nov		23d.	Date of delive	эгу
	death	Physiclan/M	in the past 12 months? 1 ☐ Yes 2 ▼No		gnant at time of dea		Ectopic pregnal Other (specify)				Month	Day Year
P.0	at the de d by the e etached	Phy	9 Unknown									
of Vital Records,	The law requires that the death cert te has been signed by the attending tage 2 should be detached for use	by	Part if Other significant con		death but not resul	ting in the ur	nderlying cause	given in Part I.	23e. Did 1			ne cause of death?
၀ွ	s bee	plet	Depress	ion					24a. Was		b. Were auto	psy findings available
E E	sician: The law certificate has I irector, page 2 s	Completed	7						auto perfo	ormed? 2 No	death?	mpletion of cause of 2□ No
ita	striffica ctor,	Be	25. Was case referred to me- examiner?	dical				26. Place of De	eath Check onl			
) V	≥ .99 ₽	흔	1 Yes 2 No	Hospital: 1	Inpatient 2 🗆 E	R/Outpatien	t 3 DOA	Other: 4 \(\text{Nursing}	Home 5 ☐ Resi	dence 6 X	Other (Specify	Hospice
	ding Ph th. After th funeral	on:	27. Manner of Death 1 ☐ Natural 5 ☐ Pe	nding (Mo	nth, Day Year)	28b. Time of Injury		Vork?	28d. Describe	now injury oc		
Division	Hospital or Attending 24 hours after death. Funeral Director: After tely filled in by the fune	Certification;		uld not be		3:30		Yes 2 No				10-1-1
ΟįΧ	or A	ertif	4 ☐ Homicide de	buil	ce of Injury - At honding, etc. (Specify)		_		City or To	wn, State)		I Route Number,
	spital ours ours neral filled		29a. Certifier 1 Cert	ifying Physician: To th	15 ing FACI						,	
	e Hos 24 h e Fur letely	Medical	(Check only 2 Med	ical Examiner: On the	basis of examination	on and/or inv	estigation, in m	y opinion, death occ	curred at the time,	date and place	e, and due to	the cause(s)
	To the Hospital of within 24 hours af To the Funeral D completely filled in	Me	29b. Signature and little of ge	rtifier	150		29c. Lice	ense number			ned (Month, I	
			DON H	Thony,	Kiler.	no	02	5205		Octo	berl	8,2005
			30. Name and address of per	son who completed car	use of death (Nem :	23а) (Туре,	Print)	66	501 N. Ch	arles	Street	
			W. A-12	LRY	Alis i ii				wson, Md			
	Sta Registi		31. Date filed (Month, Day, Y	- 0000	Adgistrar's Signatu	× A		10				

			1 - For State Registrar	State of M	aryland / Dep <i>Ce</i>	artment o			giene 2004	36710
	Physici	an	1. Decedent's Name (First, Middle,	Last)	-			2. Date of Dea Month	th Day Year	3. Time of Death
	/Medi		Dorothy		E.	Ke	lly	Nov.	17, 2004	3:30 PM [™]
7	Examir	ner	4a. Facility Name (If not institution,	give street and number)		4b. City, Tow	n, or Location of Death	1	4c. County of Dear	th
			Oak Lodge Seni 5. Social Security Number	or Home	a da um la să binta de	Pasad	ena ear If Under 24 Hrs.	1	Anne Ar	undel
	Funeral Director		216-03-2688	6. Sex 7. Ag 1 M 2	ge (In yrs. last birthday Yrs.	Months Da		8. Date of Birth (Month, Day	, Year) Co	hplace (State or Foreign
			Usual Residence of Decedent		01			July 20	1,191/ Mar	yland
	rylan how		10a. State 10b. County		10c. City, Town or L	ocation				10d. Inside City Limits
	ith the Marylar or 28a-f show e notified at	to I	Maryland Anne	Arundel	Pasad	dena				1 ☐ Yes 2 Mo
	or 28	Director	10e. Street and Number			10f. Zip Cod	le	1	10g. Citizen of What Co	ountry?
	ath w	rai	119 Montrose R			211			U.S.A.	
	ltems	Funerai	11. Marital Status	12. Was Decedent Armed Forces?	,	Was Decedent of Yes, specify C	of Hispanic Origin? (S Juban, Mexican, Puert	pecify Yes or No- o Rican, etc.)	14. Race - Ame Black, Whit	
36	rs att		1 ☐ Never Married 2 ☐ Marrie 3 🏿 Widowed 4 ☐ Divorced	ed 1 □Yes 2 ☑ If Yes, Give Year or Dates:	No	1 ☐ Yes 2 🖬	No Specify:		Specify:	
21215-0036	n 72 hours atter death with the Maryland "natural", or Items 23a or 28a-f show calcal Exercitast be notified at	Completed by	15. Decedent		16a. Dece	dent's Usual Oc	cupation		16b. Kind of Business/	<u>White</u>
215	within 73 ene. then "n	plet	(Specify only highest Elementary/Secondary (0-12)	grade completed) College (1-4or	(Give	kind of work do DO NOT use re	ne during most of wor. tired)	king		
21	d with	mo	12	N/A		tle Ex	kaminer		M.V.A.	
р	2 should be filed withir and Mental Hygiene. Is marked other than aumatic event, I're M.	BeC	17. Father's Name (First, Middle, L					ne (First, Middle.	Maiden Sumame)	
/lai	should be nd Mental r marked o	To E	Charles		Sturm		Charlo	tte		Pearce
Maryland	and ls me	ľ	19a. Informant's Name/Relationsh	ip (Type, Print)	19b. Mail	ng Address (Str	eet and Number or Ru	ral Route Number	r, City or Town, State, 2	(ip Code)
	2 = Z		Bruce H. Sturm	(Nephew)	210	Poplar	Ridge Roa	ad Pasade	ena, Maryla	nd 21122
3altimore,	0 0		20a. Method of Disposition 1 Surial 2 □ Cremation	3 □Removal from State	20b. Place of Dispersion Commetery, cre	osition (Name of matory or other	place)	Date	20c. Location - City or	Town, State
Ë	ment tant:		`4 □Donation 5 □ Other (Sp		Western	Cemeter	v 11/2	0/04	Baltimore,	Maryland
3ali	permit. Pag Department Important: I any injury o		21. Signature of Funeral Service L	icensee	2 N	2. Name and A	ress of Facility	1		
_	707 e d		John F.	Ollin	3	204 Mou	ntain Road	Pasaden	ome, P.A. a, Marylan	21122
П			23a. Part1. Enter the disease, or o shock, or heart failure. List of	complications that caused only one cause on a ach li	i ine death. Do not en	ter the mode of	dying, such as cardiac	or respiratory arr	est,	Approximate Interval Between
	Pnysician	0 1	Immediate Cause (Final disease or condition	-a Jtr	off					Onset and Death
	/Medical Examiner		resulting in death)	Due to or as	a consequence of):					1
6		_	Sequentially list conditions,	b	a consequence of):					
	ted nsit	Examiner	i any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Dae to (Sr as	a consequence ory.					
	ate be executed hysician and the burial-transit	xar	that initiated events resulting in death) Last	c Due to (or as	a consequence of);					
8760,	siciar buria	dicai E								
687		edic		0.			-			
Вох	death certific e attending p id tor use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome					23d. Date of deli	verv
B		icia	in the past 12 months? 1 ☐ Yes 2 ☑ No	4 Pregnant at		⊒Ectopic pregna ⊒ Other (specify,			Month	Day Year
0	that the d	hys	9 Unknown	9□ Unknown						
S, D	law requires that the as been signed by th 2 should be detache	by P	Part II. Other significant condition	s contributing to death b	ut not resulting in the u	nderlying cause	given in Part I.	23e. Did tob	pacco use contribute to	the cause of death?
rd	w require been sig should b							1 □ Ye	es 2 2 No 3 ☐ Pro	bably 4 Unknown
Record	e law re has ber je 2 sho	ompieted						24a. Was a		opsy findings available
Ä	0 - 0	mo:						autops perform	ned? death?	ompletion of cause of
Vital	ician: Th certiticate rector, pag	BeC	25. Was case referred to medical examiner?				26. Place of Dear	th (Check only on		
of V	S S	10	1 Yes 2 D	Hospital: 1 ☐ Inpatie	ent 2 ER/Outpatier	nt 3 DOA	Other: 4 Nursing Ho	ome 5 Reside	ince 6 Definer (Spec	ity) Assisted 40
0	ding Pth h. After th tuneral	:uo	27. Manner of Death 1 Death 5 ☐ Pending	28a. Date of Inju (Month, Da	ry 28b. Time o y Year) Injury	f 28c. Ir	njury at Vork?	28d. Describe ho	w injury occurred	C
sio	Attending in death. sctor: After by the tune	catl	2 Accident investigation in Suicide 6 Could no			M 1	Yes 2 No			7
Division	at or Attend atter death Diractor: / d in by the t	Certification:	4 Homicide determin	led 289. Place of Inj	ury - At home, farm, st c. <i>(Specify)</i>	reet, factory, office	DB	28f. Location (St. City or Town	reet and Number or Ru ı, State)	ral Route Number,
	Hospital or 24 hours afte 1 Funaral Dire stely filled in t		00-0-0-0	Mariana Tara						
	Hos 24 ho Fun Fun	edicai	29a. Certifier 1 Certifying (Check only 2 Medical E	Physiciam. To the best xaminer: On the basis of and manner sta	t examination and/or in	n occurred at the vestigation, in m	rtime, date and place, y opi <mark>nion,</mark> death occur	and due to the ca red at the time, da	use(s) and manner as ate and place, and due	stated. to the cause(s)
	To the Hos within 24 h To the Fur completely	Mec	29b. Signature and title of certifier	and mailler sta	L>-	29c. Lice	ense number	29	9d. Date signed (Month	Day Year)
	F ≯ F ŏ		> 0/1/20th	Mia	7		20094		11/18/	1
	1.		30. Name and address of person w	ho completed cause of a	eath (Item 23a) /Tuc-	Print)	- 11		11/1	7
	V		1411 Guder	- Pato.	The Gler	BUCA	18 und 21	061	()	
	Sta	te	31. Date filed (Month, Day, Year)	32. Registr	ar's Signature	,	1	- /		
	Registr	ar	NOV 1 9 2	004 Sine	va B	Sport	2			

0		end item#23P11,2 1- State Registrar			Certi	ificate of l	Death		Reg. No.	2001	3671
	an	1. Decedent's Name (First, Middle	, Last)					2. Date of De Month	eath Day	y Year	3. Time of Death
Physicia /Medic	1.4	Egbert			Lawre			9	23	3 200	1 3:08 P
Examin	er	4a. Facility Name (If not institution, Union Mem. Hos		mber)	'	•	Location of Death		4c.	. County of Dear	th
Funeral		5. Social Security Number	6. Sex	7. Age (In yrs. last b		If Under 1 Year	If Under 24 Hrs.	8. Date of Bi	rth	NA 9. Bin	thplace (State or Fore
Funerai Director		265-92-3213	1 X ☐M 2☐F	78		Months Days	Hours Min.	(Month, D	ay, Year)	Ca	nacia
		Usual Residence of Decedent								- Odi	
r 28a-f show	7	10a. State 10b. County		10c. City, To							10d. Inside City Lim 1 X Yes 2 □
28a-f	Director	Md. Na	<u>A</u>	Ba.	ltimo	re 10f. Zip Code			10g Citi	izen of What Co	
Baor	iDir	5929 Ayleshire	e Rd			2123	a		rog. Oil	USA	outiny:
natural', or Itams 23a or 28a-f show Jigal Examiner must be notified at	Funerai	11. Marital Status	12. Was Dece	edent Ever in U.S.	13. Wa		ispanic Origin? (Sp In, Mexican, Puerto	ecify Yes or No	0-	14. Race - Ame	
or Ital		1 Never Married 2 Marri	Armed Fo 1 ☐ Yes If Yes, Giv					Rican, etc.)		Black, Whit	e, etc.
Eva .	d by	3 Widowed 4 □ Divorced	Year or D	ates:		Yes 2 No	Specify:			Specify:	Black
"natural" edical Ex	Completed	15. Decedent (Specify only highes		16	(Give kit	nt's Usual Occupand of work done	during most of work	ing	16b. Ki	ind of Business	/Industry
	mp	Elementary/Secondary (0-12)	College (1	I-4or 5+)	Labo	NOT use retired	"		Par	om transle	- 10
Hygi thar int.		12th grade 17. Father's Name (First, Middle, I	Last)		Labo	rer	18. Mother's Name	e (First, Middle		rm Worke	3Ľ
	To Be	Samuel		Lawrenc	2		Blanch	16		Afflio	rk
th and Men 7 Is marka traumatic	-	19a. Informant's Name/Relationsh	nip (Type, Print)			Address (Street a	and Number or Rura		er, City o		
		Albert U. Lawre	ence :	Son	5929	Avlesbi	re Rd., E	altimo	re, N	vd. 212	239
-= 0		20a. Method of Disposition		20b. Place	of Disposit	tion (Name of tory or other place		Date		ocation - City or	Town, State
nent o		1 Deurial 2 □ Cremation 4 ☑ Donation 5 □ Other (Sp			a Mem	. Pk.	9-28	3-04	Rar	ndallsto	own, Md.
Department Important: I any injury o		21. Signature of Funeral Service I	icensee 1 04	\cap	22. 1	Name and Addres	ss of Facility	Balt		e, Md.	21202
6 # 4 0.		Muly X	1. Walt	Uy pr		arch F.H		1101 1	E. No	orth Ave	
		23a. a t1. Enter the disease, or shock, or heart failure. List	complications that conly one cause on e	aused the death. Do	o not enter	the mode of dyin	g, such as cardiac	or respiratory a	arrest,		Approximate Interval Between
iysician		Imn e late Cause (Final distast or condition resulting in death)	a. 54	Sdural	He	matom	6-				Onset and Death
Medical xaminer		res many in death)	Due to	(or as a consequence	e of):						1
	<u></u>	Sequentially list conditions,	b. — Due to	(or as a consequence	e of).		19	1	ters	Lun	2
nsit	nin	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		(0.000			Thouse	- OVED BY ME	DICALEA	MINER	
cian and ourial-transit	Examiner	that initiated events resulting in death) Last	C. Due to	(or as a consequence	e of):		CERTIFICATION AS	PORCIVED			
physician s the buria	-		d								
2 -	ledi								-1-		
ig ph as th	5	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, out	come of pregnancy birth 2 Tetal deat	th 3∏E	ctopic pregnancy				23d. Date of del	,
ending ph r use as t		in the past 12 months?		ant at time of death		Other (specify)				Month	Day Year
ne attending phed for use as t	sicia	1 ☐ Yes 2 ☐ No	0 - 0 1111111	01711							
d by the attending pt etached for use as t	Physicia	9 🗌 Unknown					and Board	oo- Did		ise contribute to	
signed by the attending pt be detached for use as the	by Physician/Medica	9 ☐ Unknown Part II. Other significant condition	-		_	, ,					
een signed by the attending ph hould be detached for use as t	þ	9 □ Unknown Part II. Other significant condition Hypertensive a	theroscle	rotic car	_	, ,					
has been signed by the attending pt e 2 should be detached for use as t	þ	9 ☐ Unknown Part II. Other significant condition	theroscle	rotic car	_	, ,		1 🗍 24a. Wasauto	Yes 2	No 3 Pr	obably 4 Unkno
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4 hours after death. Funeral Diractor: After this certifica ely filled in by the funeral director, p	edical Certification; To Be Completed by	9 Unknown Part II. Other significant condition Hypertensive a End stage rena 25. Was case referred to medical examiner? 1X Yes 2 1No 27. Manner of Death 1 Natural 5 Pendin investig 1 Natural 2 Accident 3 Suicide 4 Homicide 6 Could referred to medical examiner? 29a. Certifier (Check only one)	Hospital: 1 28a. Date (Mon. Sept not be ined 28e. Place buildi ug Physician: To the Examiner: On the band man	Inpatient 2 ER/C of Injury th, Day Year) 2004 union of Injury - At home, ng, etc. (Specify) nknown best of my knowled, asis of examination a ner stated.	Dutpatient Time of Injury Iknow farm, stree ge, death o	3 DOA Other 28c. Injury Work 1 To the factory, office occurred at the tim stigation, in my of 29c. License AT 2	26. Place of Death er: 4 Nursing Ho y at y? Yes 2 No ne, date and place, pinion, death occurr e number	24a. Was auto perfu perf	Yes 21 s an psy promed? 2 \(\text{No} \) No one) idence to how injury hole f (Street an win State,	24b. Were at prior to death? 1 Yes 6 Other (Spery occurred and manner as at place, and due te signed (Montal)	utopsy findings availacompletion of cause 2 No cify) ural Route Number, stated. to the cause(s) h, Day, Year)

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** LOI November 14 2004 /Medical 4a, Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Harbor HOSPITA N/A 8. Date of Birth (Month, Day, Year) Nov. 24, 1946 5. Social Security Number 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) 6. Sex **Funeral** 10M 20F Months 5 253 74 6847 Nov. Director Georgia Usuel Residence of Decedent the Maryland 10c. City, Town or Location 10a. State 10b, County 10d, Inside City Limits 7 is marked other than "natural", or items 23s or 28e-f show traumatic event, the Medical Examinat rivet to inclined all 1 Yes 2 □ No Maryland N/A Directo Baltimore 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 1642 Caddox Street 21226 U.S. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ges 1 and 2 should be filled within 72 hours after of Health and Mental Hygiene.
If item 27 is marked other than "natural", or Iter 197Yes 2□No IYes, Give Viet Nam Year or Dates: Viet Nam 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White ò 3 ☐ Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Construction Truck Driver 7th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) John Henry Lolies Rosa Hall 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Deanna Lolies / Daughter 1142 Monroe Circle Baltimore, Maryland 21225 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 1 ☐ Burial 2 Cremation 3 ☐ Removal from State ō Bayview Crematory 11/15/2004 Baltimore, Maryland * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Gonce Funeral Service, P.A. 21. Signature of Funeral Service Licensee 4001 Ritchie Highway Baltimore, Maryland 21225 Implications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ity one cause on each line. 23a. Part 1. Enter the disease of comshock, or heart failure. List only Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pnysician WITH -4NG Concer /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, it any Leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of attending physician and for use as the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medicai IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐ Pregnant at time of death 9☐ Unknown 5 Other (specify) ed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ pe 1 Yes 2 No 3 Probably 4 → Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 X No 1 ☐ Yes 2 ☐ No after death.

Director: After this certific Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ☑ ER/Outpatient 3 ☐ DOA ပို 1 Inpatient 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manper of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completely filled in by determined 4 Homicide within 24 hours a 1 Crafifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier 00052022 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) nover St. Baltimore Maryland 21225 Kove 31. Date filed (Month, Day, Year) 32. Registrar's Signature State NOV 1 9 Registrar

			For State Registrar		State of	of Mary					ealth a		ental Hy	giene Reg. No		0.00
			Decedent's Name (First,	Middle, Las	t)								. Date of De	ath	C U U 14	9. There of Death
	Physicia /Medic		TYE DO	OUGLAS	MARTII	V							Month NOV	Day 15		11 15 M
	Examin		4a. Facility Name (If not ins	stitution, give	street and nu	imber)	ol Ce	nter	4b. City,	17 1	Location of	of Death		4c.	. County of Dea	a contract of the contract of
	F		Feninsula 5. Social Security Number	6. Se			yrs. last bir		If Unde	r 1 Year	bury If Under	24 Hrs. 8	B. Date of Bir	th	W. Con	thplace (State or Foreign
	Funeral Director		547-24-3423		∑ M 2□F		1	Yrs.	Months	Days	Hours	Min. F1	EB • 4	y. 19 2	23 ORF	EGON
	pu 🛾		Usual Residence of Deced	lent County		100	c. City, Tow	n or Loc	cation							10d. Inside City Limits
	Maryla f sho	0		OMERSE'	Т		IANOKI									1 ☐ Yes 2 ☐ No
	ath with the Marylan s 23a or 28a-f show ust be notified at	Director	10e. Street and Number						10f. Zip	Code				10g. Cit	tizen of What Co	ountry?
	th with	al D	8510 RIVER	ROAD					2	1836_				UNIT	ED STAT	ES
	ler dea	Funeral	11. Marital Status		12. Was Dec Armed F	orces?	in U.S.	13. V	Vas Dece Yes, spe	dent of Hi offy Cuba	ispanic Ori n, Mexicar	igin? (Speci n, Puerto Ri	fy Yes or No can, etc.)	-	14. Race - Ame Black, Whi	
36	72 hours after death with the Maryland naturel; or Items 23e or 28e-f show deal Examinet rust to multified at	by F	1 ☐ Never Married 2[3 ☐ Widowed 4 ☐ Di		If Yes, G Year or [2 □ No ive 1 0 Dates: 1 0	81-	1	Yes	2 X No	Specify:				Specify:	WHITE
21215-0036	"naturel", or	eted		ecedent's Ed	ucation de completed,			. Deced	ent's Usu	al Occupa	ation during mos	t of working	7	16b. K	and of Business	/Industry
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<u>lan</u>	should be filed within and Mental Hygiene. s marked other then umetic event, the Mental Control of the Mental Control of the Mental Control of the Mental Control of the Mental Office of the Mental of the Mental Office o	To Be	J.J. MARTIN	N							CLAR	A I. 3	JOHNSO	N		
Maryland	2 20 20	. 9	19a. Informant's Name/Re						•						or Town, State,	
	s 1 and 3 of Health item 27 other tr		ALLEN D. MA		- SON	2	Ob. Place of				AND 1	NOAEM BTKE			ocation - City or	YLVANIA Town, State
nor	00		1 □ Berial 2 ♣ Cren 4 □ Domation 5 □ 0	nation 3 🗆		State	cemete. IETRO	ry, crem	natory or o	other place	θ) ' ΄	19, 20				E, MARYLAND
Baltimore,	permit. Pag Department Importent: I any injury o		21. Signature of Funeral S	-		Ir.	IETRO	22.	. Name a	nd Addres	s of Facili			ME T		21061
<u> </u>	88 5 6	7 10	Ten	May	X			_			PPGHW.		-		ŔŇĬE, M	IARYLAND
			23a. Part1. Enter the dise shock, or heart failur	ase, or comp e. List only	olications that one cause on	caused the each line.	death. Do			/			respiratory a	rrest,		Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	-		Ocute Of or as a con		na	l f	all	urc					2 days
п	Examiner				Due (0	ate	, al	· /	161	11/10	a for	^				4-5 day
	p #	iner	Sequentially list conditions if any, leading to immedia cause. Enter Underlying Cause (Disease or injury	s, te	Due to	(or as a co	nsequence	of):								UT
	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Examiner	that initiated events resulting in death) Last	1	c	CM (or as a po	gent psequence	of):	1 /	lar,	f- f	11/	url	-		4-1 dags
8760,	icate be ex physician s the buria	dical E		l	d		<u> </u>									
9	ng phys	a a	IF FEMALE:													
Вох	leath certific attending p	Physician/M	23b. Was decedent pregn in the past 12 month			utcome of pr birth 2 Inant at time	Fetal death		Ectopic p						23d. Date of de Month	livery Day Year
o.	that the de led by the a detached f	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown		9□ Unki		or dealir	3	TOTHER (S)	Jecliy)						
Δ.	uires that signed b d be deta	by PI	Part II. Other significant of	conditions c	ontributing to	death but no	t resulting i	n the un	iderlying (cause give	en in Part I		23e. Did t	obacco	use contribute to	o the cause of death?
ord	w require been sig should b	ted											1 🗆	Yes 2	800 3□P	robably 4 Unknown
Records,	has by	Completed											24a. Was		24b. Were a prior to death?	utopsy findings available completion of cause of
Vital B		e Co	25. Was case referred to	medical							26 Place	of Death /	1 ☐ Yes Check only	20 No		3 2 □ No
ί	Physician: this certific ral director,	To B	examiner? 1 ☐ Yes 2 No		Hospital:	Inpatient	2 🗆 ER/O	utpatient	t 3 🗆 D	OA Othe	0.00			-	6 ☐Other (Spe	ocify)
n of	ing Ph		27. Manner of Death	Pending	28a. Date (Moi	of Injury nth, Day Ye		Time of Injury		28c. Injury Work	</td <td></td> <td>d. Describe</td> <td>how inju</td> <td>ry occurred</td> <td></td>		d. Describe	how inju	ry occurred	
Division	death, ctor: A	ficat	2 Accident	Could not be		e of Injury -	At home, fa	arm, stre	M eet. factor		Yes 2□	_	f. Location (Street ar	nd Number or R	ural Route Number,
Ο̈́	el or A s after il Dire	Certification:	4 🗍 Homicide	determined	buile	ding, etc. (S	pecify)	,		,,			City or To	wn, State	e)	
	To the Hospitel or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	Medical (29a. Certifier (Check only one)	ertifying Ph ledical Exan	niner: On the	ne best of my basis of exa nner stated.	y knowledge mination ar	e, death nd/or inv	occurred	at the time n, in my op	ne, date ar pinion, dea	nd place, an ath occurred	d due to the d at the time,	cause(s date and) and manner a d place, and due	s stated. e to the cause(s)
	To thi within To the	Me	29b. Signature and title of	certifier	1//				29	c. License	e number			29d. Da	te signed (Mon	th. Day, Year)
			1/4	HIL	13/				- 2	100.	599	3/		j	1/17/0	4
1			30. Name and address of		completed cau	ase of death			Print)	Ani		MI	218	C 2	, ,	
	Sta	ite	30434 Mour 31. Date filed (Month, Day		32.	Pegistrar's		nu		FILL			610			
	Regist		31. Date filed (Month, Day	1 9 201	14	Jepan	~ /	9	So	all	/					

547-24-3423

Tye martin

			For State Registrar	State of M	Maryland / Dep	ertificate of				4 36714
	Physici	an	1. Decedent's Name (First, Middle,	Last)				2. Date of Dea Month	th Day Ye	3. Time of Death
	/Medic	al	Bruce Allen Me 4a. Facility Name (If not institution,	erryman	r)	4h City Town	or Location of Death		17 200 4c. County of D	
1	Examin	er	39 Bernadotte		,	Baltin			Balti	
	Funeral			6. Sex 7. A	ge (In yrs. last birthda			8. Date of Birth (Month, Day 07/27/	year) 9.	Birthplace (State or Foreign Country)
	Director		215-44-2071	1 ⊠ M 2□F	57 Yrs.		110010	07/27/	1947	Maryland
	ow ow		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or	Location				10d. Inside City Limits
	ith the Marylar or 28a-f ehow	tor	MD Balt	imore	Baltim	ore				1 ☐ Yes 2 🖔 No
	or 28	Olre	10e. Street and Number		177	10f. Zip Code			10g. Citizen of Wha	t Country?
	death with the Maryland ims 23a or 28a-f ehow	ral	39 Bernadotte	Court 12. Was Deceder	t Francis II S	21234		a sifu Van as Na	U.S.A.	American Indian,
	ritem ritem	by Funeral Director	11. Marital Status 1 Never Married 2 Married	Armed Forces	Vietnam	. Was Decedent of H If Yes, specify Cub		Rican, etc.)	Black, V	Vhite, etc.
036	hours after turel', or ite	l by	3 Widowed 4 Divorced	If Yes, Give Year or Dates	Era	1 ☐ Yes 2 🔀 No	Specify:		Specify:	White
21215-0036	72 hours after dea "naturel", or Items coloul Examinat m	Completed	15. Decedent' (Specify only highest	s Education grade completed)	16a. Dec	edent's Usual Occur e kind of work done	during most of worl	king	16b. Kind of Busin	ess/Industry
121	e filed within Il Hygiene. other than	dwc	Elementary/Secondary (0-12)	College (1-4o	r 5+)	DO NOT use retire			Telephon	
	e filed Il Hygi other	Be C	17. Father's Name (First, Middle, L	ast)		I VICE ICC	1	e (First, Middle,	Maiden Sumame)	
/lar	thould be and Mental marked of matic even	ToE	James Albert 1	Merryman			Ethel I	. Hieror	nimus	
Maryland	12 sho		19a. Informant's Name/Relationsh			lling Address (Street				
	ges 1 and 2 should be filed within 72 hours after death with the Maryla to f Health and Martal Hygiens are the state of t		Deborah J. Me: 20a. Method of Disposition	rryman (wif	20b. Place of Dis	position (Name of			ce Maryl 20c. Location - City	or Town, State
Jor	ages ent of nt: If it		1 X Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp		0	ematory or other pla	1	7/2004	Arlington	, Virginia
Baltimore,	permit. Pages 1 and Department of Healtl Important: If Item 2; any injury or other t		21. Signature of Funeral Service L							al Home, P.A.
<u> </u>			C. S. Xa	roadn		1750 Bela				yland 21087
			23a. Part1. Enter the disease, or of shock, or heart failure. List of	nly one cause on each	line.					Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a ESOF	hageal is a consequence of):	Cancer	v-me	tasta	TC	13 MONTHS
	Examiner			Cor2	ONARY A	PTERM	DICEDO	SE		VEARS
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events.	Due to (or a	is a consequence of):	ere in	V10011	φ		10
	and transl	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c	-0					
760,	ite be executed ysician and ne burial-transit	Ical E	rossining in doubly East	Due to (or a	is a consequence of):					
687	# % e			d						
Вох	death certificat e ettending phy od for use as th	M/UE	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom		Ectopic pregnanc	ev.		23d. Date of	
	0 0 0	Completed by Physician/Med	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown			Other (specify)			Month	Day Year
P.0	requires that the een signed by th hould be detache	, Ph	Part II. Other significant condition	s contributing to death	but not resulting in the	underlying cause gr	ven in Part I.	23e. Did to	bacco use contribu	e to the cause of death?
rds,	w requires that been signed k should be det	d b	HOLGH BLOOD	PRESSURE	-			1 🗆 Y	es 2 🗆 No 3 🗆	Probably 4 Unknown
CO	- D 70	plete						24a. Was a	an 24b. Wer	autopsy findings available
R	The ate h page	Com						perfor	ned? deat	to completion of cause of h? Yes 2 \sum No
/ita	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:		04	han	th (Check only or	ne)	
of	Phys this ral dii	2	1 ☐ Yes 2 No 27 Manner of Death	1 🗆 Inpa	tient 2 ER/Outpati	ent 3 DOA	her: 4 Nursing H		ence 6 Other (:	Specify)
on	Attending Phyrideath. ector: After thiby the funeral	tlon	1 Natural 5 Pending 2 Accident investig		Day Year) Injury	Wo	rk?]Yes 2 □ No			
Division of Vital Records,	er dea rector by th	Certification;	3 ☐ Suicide 6 ☐ Could n 4 ☐ Homicide determi	and 289, Place of I	njury - At home, farm, : etc. (Specify)	street, factory, office		28f. Location (S. City or Town	treet and Number o	r Rural Route Number,
D	ital or irs aft ral DI	Cer								
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: Att completely filled in by the fun	edical	29a. Certifier Certifying (Check only one)	Physician: To the best examiner: On the basis and manner	of examination and/or	ath occurred at the ti investigation, in my	ime, date and place, opinion, death occur	and due to the c red at the time, d	ause(s) and manne late and place, and	r as stated. due to the cause(s)
	o the	Med	29b. Signature and title of certifier	and mariner	stateu.	29c. Licens	se number	2	29d. Date signed (M	lonth, Day, Year)
	. \		· alue t	er us	_	D59	1805	1	Vov 18th	2004
1º	14,		30. Name and address of person v	who completed cause of	1 11 -				MO 212	2/
1-			ALICE LEE 31. Date filed (Month, Day, Year)	4424 Car	upicell Bl	vd. #20	O BACT	more	MUZIL	ラ ん
	Sta Regist		NOV 1 9	2004	eneva L	Span	61			

				State of Maryland / Department of Health and M	-			
				1- State of Maryland / Department of Fleath and N		g. N2004	36715	
		0		Negistrar 1. Decedent's Name (First, Middle, Last)	2. Date of Death		3. Time of Death	
_		Physici		Kyree Michael Anthony Mitchell	Month	Day Year	11 10 PM	
		/Medio Examin		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death		4c. County of Dea		
				Upper Chesapeake Medical Center Bel Air		Harfo		
		Funeral		5. Social Security Number 6. Sex 1X2 M 2 F 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Wonths Days Hours Min.	8. Date of Birth (Month, Day, NOV. 15	Year) 9. Bir	thplace (State or Foreign ountry) aryland	
10		Director		Usual Residence of Decedent	1100. 13	, 2004 Mc	шутапа	
50		yland		10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits	
30		e Ma	ctor	Maryland Harford Elkton			1 ☐ Yes 2 No	
8		death with the Maryland ms 23a or 28a-1 show rmust be notified at	Funeral Director	10e. Street and Number 17 North Navaho Trail 21921	10	g. Citizen of What Co	ountry?	
		eath v	eral		acify Vas or No-	USA 14. Race - Ame	ancan Indian	
	"	fter d r fter	Fun	Armed Forces? If Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	Black, Whit		
2	93	hours after tural', or Ite al Examina	þ	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:		Specify:	Black	
11/15/04	5-0	72 ho	Completed	15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of work life. Do NOT use retired)	king	6b. Kind of Business	/Industry	
100	121	within ane. than	mpl	Elementary/Secondary (0-12) College (1-4or 5+) Never Worked				
1	d 2	filed within 72 h I Hygiene. other than "natt ant, the Medica	e C		e (First, Middle, M	faiden Sumame)		
	'lan	uld be Mental rked tic av	To Be	Michael Lamont Mitchell Michel	le Ann	Sjolie		
	lary	s 1 and 2 should be filed within 72 hours after death with the Marylan if Health and Mental Hyglene. Itam 27 is marked other than "natural", or Items 23a or 28a-1 show other traumatic avant, the Medical Examiner must be notified at		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rus	ral Route Number,	City or Town, State, .	Zip Code)	
24	<u>~</u>	1 and 2 Health am 27 i		Michelle A. Sjolie / Mother 17 North Navaho Trail 20a Method of Disposition (Name of		MD 21921		
33	Jor 6	ages of the of H		1 Burial 2 Commation 3 Removal from State	_	·		
42832	Baltimore, Maryland 21215-0036	permit. Pages 1 Department of H important: If its any injury or ot once.				Iowson, Ma	-	
	Ba	Dep imp any onc		21. Signature of Funeral Service Licensee McConfas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, MD 21009				
#		-		23a. Part1. Enler the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on each line.			Approximate Interval Between	
Anthony Mitchell		Physician		Immediate Cause (Final disease or condition EXTREME PREMATURITY Onset and Death 5 MIN				
		/Medical Examiner		resulting in death) Due to (or as a consequence of):				
			, i	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of).	MEMBRA	4NES	27 Hours	
40	VI	uted	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.				
Z	o,	ate be executed ysician and he burial-transit	Еха	resulting in death) Last				
ny ny	3760,	ate be hysicia he bu	Icat	d				
ho	x 68	entific ding pl	/Med	IF FEMALE: 220 If you system of promoter				
Int	Box	attenc for us	ian	23b. Was decedent pregnant in the past 12 months? □ University by the past 12 months? □ University by the past 12 months? □ University by the past 12 months? □ University by the past 12 months?		23d. Date of del Month	livery Day Year	
	P.O.	the de y the ached	Physician/Med	1 Yes 2 No 9 Unknown 9 Unknown				
2	Records, P	requires that the death certifical been signed by the attending phy should be detached for use as th	by PI	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tob	acco use contribute to	the cause of death?	
Michael		equire en sig ould b	ed b		1 ☐ Ye	s 2 No 3□Pr	obably 4 Unknown	
Mic	ecc	The law re te has be vage 2 sho	Completed		24a. Was an autopsy	prior to	utopsy findings available completion of cause of	
	H		Соп		perform 1 ☐ Yes 2	ed? death? XNo 1 ☐ Yes	2 No	
ig	Division of Vital	yslcian: is certific director,	Be	25. Was case referred to medical aximiner? 1 Type 20/No Hospital: 10/1000/jung/jung 20 FB/Outgations 30 DOA Other. (Case): 10/1000/jung/jung 20 FB/Outgations 30 DOA Other.				
Kyree		ing Phy iner this	To To	27. Manner of Death 28a. Die of Injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred				
-X			atior	1 ★Natural 5 Pending (Month, Day Year) Injury Work? 2 Accident investigation M 1 Yes 2 No				
્થ	Vis	er deg ractor by th	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Str. City or Town,	eet and Number or Ru State)	ural Route Number,	
_0	D	ital or irs afte ral Dir	Cer					
5	.	Hos Fur faky	edical	29a. Certifier (Check only one) Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, (Check only one) Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occur and manner stated.	and due to the car red at the time, da	use(s) and manner as te and place, and due	s stated. to the cause(s)	
		within 2	Me	29b. Signature and title of certifier 29c. License number	29	d. Date signed (Mont	h, Day, Year)	
		F > F 0		D 33079		11-16-	04	
				30. Name and address of person who completed cause of death (Item 23a) (Type, Print)				
JUN BELLANTONI UPPER CHESAPONKE MEDILAR CENTER BELAIR, State 31. Date filed (Month, Day, Year) 32. Registrar's Signature							, my cioly	
1		Sta Regist		NOV 1 9 2004 Berne & Spark				

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien [] 1 - State Registra Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 200 30 AM Morris /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner HOSP 5. Social Security Number 05 9 0 If Under 24 Hrs. 8. Date of Birth (Month, Day, 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1X M 2□ F 67 Director 219-26-1487 VA. Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits 10a. State ral', or Items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2 XNo Director Dundalk MD. Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21222 USA 1729 Drexal Road Completed by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. ☐Yes 2 XNo 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Specify: White If Yes, Give Year or Dates: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry other than Elementary/Secondary (0-12) College (1-4or 5+) Hygiene Chemical Company 9 years Machine Operator 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 2 should be finance of Mental H Blanche M. Shifflett Henry William Morris 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Pages 1 and 2 s ment of Health an permit. Pages 1 and 2 Department of Health a Important: If Item 27 Is any injury or other trai QDCS. 1729 Drexel Road, Dundalk, MD. 21222 Juanita Morris 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition November 1 🔀 Burial 2 □ Cremation 3 □ Removal from State Sacred Heart Of Jesus Cem. 20, 2004 Dundalk, MD. 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Connelly Funeral Home Of Dundalk, P.A. 21222 7110 Sollers Point Road, Dundlak, MD. complications that caused the death. To not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. 23a. Part1. Enter the disease of shock, or heart failure. List Approximate Interval Between Onset and Death Immediate Cause (Final + rokt **Physician** disease or condition resulting in death) /Medical **Examiner** lockage of upssels to the Brain Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed the burial-transit Due to (or as a consequence of) Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav 4☐Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an director, page 2 autopsy performed 2 No 1 🗌 Yes Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 ☑ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 / Inpatient မ 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 Pending investigation after death. 1 🗌 Yes 2 No 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a To the Funeral L 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical completely (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 30. Name and address of gerson who completed cause of death (Item 23a) (Type, Print) anklin square Olive 9000 H05521

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

NOV 1 9 2004

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32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** Year A. MIZURAK J4584 700 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** G000 HOSPITAL BALTIMORE BALTIMORE SAMARITAN If Under 1 Year | If Under 24 Hrs. Social Security Number 8. Date of Birth (Month, Day, Year) Aug. 13, 1 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1**2** M 2□F Days Hours 61 1943 Director 212-44-6178 Marvland Usual Residence of Decedent with the Maryland 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits or 28e-f show other treumatic event, the Madical Examiner must be notified at 1 MYes 2 □ No Maryland Completed by Funeral Director N/ABaltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6645 Wycombe Way Items 23a Apt. B U.S.A. 21234 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 ☐ Yes 2 1 No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupetion 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Computer Technican Alex Brown & Sons 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Joseph J. Mizurak Mary Sarisky 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) С. Mizurak (Sister) 1605 Covington Street, Baltimore, Maryland 21230 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Holy Gross Cem. 11-20-04 * 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland McCully-Polyniak Funeral Home P.A. 21. Signature of Funeral Service License 130 East Fort Avenue, Baltimore, Maryland Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only she cause on each line. mediate Cause (Final Physician ACUTE MYOCARDIAL INFARCTION isease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of): P.O. Box 68760, attending physician Physician/Medicai IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Month Day Year 4□Pregnant at time of death 5 Other (specify) þ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Be Completed by HYPERTENSION 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Nonknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 No 24a. Was an MELLITUS DIABETES 2. No 1 TYes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER Outpatient 1 ☐ Yes 2 No Certification: To 3 DOA this 27. Manner of Death 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred After 1 Natural 2 Accident 5 Pending after death. 1 TYes 2 TNo investigation 6 Could not be determined 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 24 hours a *Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only one) and manner stated. within 2 To the 29b. Signature and title of certifier 29c. License number 5 use of death (Item 23a) (Type, Print) 30. Name and address of person who con KERITH 5601 LOCH BALTIMORE, MD 21239 RAVEN 32. Registrar's Signature 31. Date filed (Month, Day, Year) NOV 1 9 2004 Registrar

		1 - For State Registrar	State of Maryland	/ Depa	rtment o	f Health of Death	and M	ental Hygi	ene 2	004	36718
Physicia /Medic	al .	1. Decedent's Name (First, Middle, Last) Eleanor Stah	,					2. Date of Death Month	14 Day	2004	3. Time of Death 9:30 P M
Examine		4a. Fecility Name (If not institution, give strauded Holly Farms Roads S. Social Security Number 6. Sex		st hirthday)		n, or Location na Parl sar If Under	k	8. Date of Birth	Ann	ty of Deeth	
Funeral Director		212-42-7395 1□ N Usual Residence of Decedent	1 2 ^M F 94	Yrs.	Months Da		Min.	8. Date of Birth (Month, Day) 11-13-19	910		olace (State or Foreign MD
rs after death with the Maryland ", or Items 23a or 28a-f show	Director	MD Anne Arund	- 1	rna Pa	ark			140	a China		0d. Inside City Limits 1 Yes 2 No
ath with the 23s or 2		10e. Street and Number 416 Holly Farms Roa		10.10		146	ining (Co.			US ace - Americ	Α
ours after	by Funeral	11. Marital Status 12 1 Never Married 2 Married 3 Widowed 4 Divorced	Was Decedent Ever in U.S. Armed Forces? 1		Yes, specify (ecify Yes or No- Rican, etc.)		leck, White,	
	Completed	15. Decedent's Educa (Specify only highest grade of Elementary(Secondary (0-12)	conpleted) College (1-4or 5+)	(Give I life. D	ent's Usual Oo kind of work do PO NOT use re Iome ma	one during mos itired)	st of worki	ng 1		Business/In	
permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 is marked other than any injury or other traumatic svent, the Magnes.	To Be C	17. Father's Name (First, Middle, Last) George E. Stal	11				E		Asend	ofs	
and 2 sho saith and 1 n 27 is mu		19a. Informant's Name/Relationship (Type Mr. Maurice D. Meye	ers/husband	416 Hc	olly Fa	rms Rd.	., Se	Verna Pa	rk, M	D 21	146
Pages 1: ment of He ant: If Iten ury or oth		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Ren 4 ☐ Donation 5 ☐ Other (Specify)	cen	netery, crem	sition (Name of natory or other MC Ceme	place)	11/1			n-City or To	
permit. Depart Import any inj once.		21. Signature of Fuperal Service Licensee	ilas Mo136	54 1		Ave SV	√ Gle	ngleton n Burnie	MD 2	al Hom 1061	
Physician		23a. Pert 1. Enter the disease, or complica shock, or heart failure. List only one Immediate Cause (Final disease or condition	tions that caused the death. cause on each line.	Do not ente	er the mode of	dying, such as	s cardiac o	r respiratory arre	st,		Approximate Interval Between Onset and Death
/Medical Examiner		resulting in death) Sequentially list conditions.	V	ence of):	V		-	<u> </u>			
be executed sician and burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conseque								
icate be physicial s the buri	edical	d							· · · · · · · · · · · · · · · · · · ·		
The law requires that the death certificate the has been signed by the attending physoage 2 should be detached for use as the	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ▼ No 9 ☐ Unknown	l. If yes, outcome of pregnand ↑ Live birth 2 Fetel of 4 Pregnant at time of dea 9 Unknown	leath 3	Ectopic pregn Other (specif					Date of delive	ery Day Year
quires that n signed build be deta	þ	Part II. Other significent conditions contributed by the Figure 1988 of the Part of the Pa	buting to death but not result	ting in the ur	nderlying caus	given in Part	l.	23e. Did tob	de de		he cause of death? pably 4 □Unknown
The law requirate has been spage 2 should	Completed	fibrillation						24a. Was an autopsy perform	/	o. Were auto prior to co death? 1 ☐ Yes	psy findings available mpletion of cause of
ysicisn: Th	o Be	25. Was case referred to medical examiner?	spital: 1 ☐ Inpatient 2 ☐ E	R/Outpatien	t 3 DOA	Other		n (Check only one		Other (Specif	'y)
nding Physath. r: After this	ertification: T	27. Manner of Death SNatural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury		Injury at Work? 1 🗌 Yes 2 🗔		28d. Describe ho	w injury occ	urred	
To the Hospital or Attending Physician: The within 24 hours after death. To the Funaral Director: After this certificate ha completely filled in by the funeral director, page	C	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At hom building, etc. (Specify)	ne, farm, stre	eet, factory, of	ice		28f. Location (Str City or Town		mber or Rura	al Route Number,
ne Hospi 24 hou na Funai bletely filt	edical		r: To the best of my know r: On the basis of examination and manner stated.								
To th within To th	M	29b. Signature and title of certifier	MD			sense number	3	29	od. Date sign	ned (Month,	Day, Year)
ЦЛ		30. Name and address of person who com	pleted cause of death (Item	23a) (Type,	Annahi	Le Ro	Parl.	#106	odu	Jon.	mDall 3
Sta Registr		31. Date (iled (Month, Day, Year)	32. Registrar's Signatu	ire So	als			1	V		, -

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend item, 1 per phys 2838 12-9-04, vt

			For State Registrar	State of Ma	arytand? D	lepartment of l Certificate of	Tealth and M <i>Death</i>		giene 004	36719
	Physici	an	Decedent's Name (First, Middle, La Susa	isi) J. an E. Marsl	nall			2. Date of Dea Month Novemb	Day Year	3. Time of Death 7:30 A.M.
	/Medio Examir		4a. Facility Name (If not institution, gir			4b. City, Town, o	or Location of Death	NOVERID	4c. County of Death	
1	Exami	G1	Genesis Elderca		use Road		na Park		Anne Aru	
	Funeral Director		5. Social Security Number 6. 212 09 8452	Sex 7. Ag	e (In yrs. last birti		tf Under 24 Hrs.	8. Date of Birth (Month, Day April 1	9 Rinth	place (State or Foreign
	show		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	or Location				10d. Inside City Limits
	a-fst	ctor	Maryland Anne A	rundel	Glen	Burnie				1 ☐ Yes 2 No
	death with the Maryland ms 23s or 28s-f show	al Director	10e. Street and Number 403 W. Ordnance	Road Apt.	412	10f. Zip Code 21	061	1	10g. Citizen of What Cou	intry?
5-0036	ours after all, or ite	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces? 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates:		13. Was Decedent of Hif Yes, specify Cub 1 ☐ Yes 2 No		ecify Yes or No- Rican, etc.)	14. Race - Ameri Btack, White Specify: Whi	, etc.
5-0	72 hours "natural", dical Ex-	etec	15. Decedent's E (Specify only highest gr	ducation ade completed)	16a.	Decedent's Usual Occup (Give kind of work done life. DO NOT use retire	pation during most of work	ing	16b. Kind of Business/Ir	ndustry
2121	within rene.	Completed	Elementary/Secondary (0-12) 12th	College (1-4or 5)+)	iife. DO NOT use retire Seamstress	d)		Garment In	ndustry
p	be filed tal Hygi d other	Be (17. Father's Name (First, Middle, Las.				18. Mother's Name			
yla	2 should be and Mental is marked (aumatic ev	4		Cannon	1			lian Gau		
Maryland	s 1 and 2 should be filed f Health and Mental Hyg item 27 is marked othe other traumatic event,		19a. Informant's Name/Relationship Jeffrey Marshal			Mailing Address (Street 2 Sunset Kn			r, City or Town, State, Zij ena, Marylar	,
	of Health item 27 other tr		20a. Method of Disposition	7 5011	20b. Place of	Disposition (Name of	! [20c. Location - City or T	
Baltimore,	Page: ento nt: If		1 ☑ Burial 2 ☐ Cremation 3 ☐ '4 ☐ Donation 5 ☐ Other (Special Service Lice	(y)		r, crematory or other pla Hill Cemeto 22. Name and Addre	ery 11/19	_	Baltimore,	
Ba	permit. I Departm Importal any inju		21. Signature of Furneral Service Lice	4.44.4	· hi	4001 Ritch			eral Service timore, Mar	
	Physician /Medical	8 10	23a Part1. Enter the disease, or con shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	applications that caused one cause in each line.	the death. Do note.	ot enter the mode of dying	ng, such as cardiac		est,	Approximate Interval Between Onset and Death
68760,	ficate be executed as the physician and as the burial-transit as	edicai Examiner	Sequentially list conditions, 1 my leading to inchediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	с	a consequence o					
P.O. Box 6	death certifi e attending od for use as	Physician/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal death	3 ☐ Ectopic pregnanc; 5 ☐ Other (specify) _	у		23d. Date of delive Month	ery Day Year
	requires that the de een signed by the a nould be detached f	þ	Part II. Other significant conditions	contributing to death b	ut not resulting in	the underlying cause giv	ven in Part I.		bacco use contribute to t	
Division of Vital Records,	The law ate has b page 2 st	Completed						24a. Was a autops perform	y prior to co	opsy findings available impletion of cause of
/ita	ding Physician: After this certific funeral director.	Be	25. Was case referred to medical examiner?	Hospitat		Low	26. Place of Death	Check only on	9)	-
of	Phys this al dir	2	1 ☐ Yes 2 D No 27. Mann Death	Hospitat: 1 ☐ tnpatie	nt 2 ER/Out		4 Nursing Ho		ence 6 Other (Special ow injury occurred	ý)
sion	ng fter inei	atlon	1 Natural 5 ☐ Pending investigation	(Month, Day		jury Wor	Yes 2 □No			
Divi	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Certification:	3 Suicide 6 Could not be determined		ury - At home, far c. <i>(Specify)</i>	m, street, factory, office		28f. Location (St. City or Town	reet and Number or Rura n, State)	al Route Number,
	he Hospi n 24 hour he Funer pletely fill	Medical	29a. Certifier (Check only one) 1	nysicien: To the best miner: On the basis of and manner sta	examination and	death occurred at the til for investigation, in my o	me, date and place, a opinion, death occurr	and due to the ca ed at the time, da	ause(s) and manner as s ate and place, and due to	tated. the cause(s)
)	To the Company of the	Σ	29b. Signature and title of certifier	n	MO	29c. Licens	o 725	. 2	9d. Date signed (Month,	2004
-			30. Name and address of person who cenniter Ried.	inger 86	01 Vete	ranstwy	M.U	rsv.lle	e Mi) à	11108
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registr	ar's Signature	for de	, 17		/	
DH	IMH 17 Rev 1/2	001	11011 0 200		100	- John Start				

ORIGINAL

State of Maryland / Department of Health and Mental Hygienes 1 - For State Registra 36720 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month Year MONTAGUE -AVERNE 9:00 AM Z NOVEMBER 15 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE N/A 2421 BAKER ST. If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 M 2 □ F 57 219-50-3018 Yrs Director 5-12-1947 MARYLAND Usual Residence of Decedent with the Maryland 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits or 28a-f ahow r than "natural", or Itema 23a or 28a-f ahov It e Medical Examinar must be notified at 1 Ty Yes 2 □ No Director MD. N/A BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2421 BAKER ST. 21216 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status permit Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or itel any in ury or other fraumatic event, the Miscales is a fundame. 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: 1 → Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Š Specify: 3 ☐ Widowed 4 ☐ Divorced BLACK Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12)
-12-College (1-4or 5+) SECRETARY DEPARTMENT OF EDUCATION 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) LULA SCOTT HERBERT MONTAGUE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2421 BAKER ST. BALTIMORE, MARYLAND 21216 LAMONT MONTAGUE (SON) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cromation 3 Removal from State MT. ZION CEMETERY 11-20-2004 BALTIMORE, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) D. HIBNER Name and Address of Facility REDD FONERAL SERVICE Funeral Service Licensee JONATHAN 21. Sign fure 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217 23a. Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician Lean Hypertoninon resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine the attending physician and hed for use as the burial-transit Mitsel Value requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 3 Ectopic pregnancy in the past 12 months? Day Month Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No detached Division of Vital Records, P.O. 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? Yes 2 No certificate 2L No 1 Yes Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica funeral director Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Sesidence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No P 1 🗌 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation М 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of dertifier 29c. License number 29d. Date signed (Month, Day, Year) Than foon, MD FALP D 51088 NOVEMBER 17, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) n Paul Place. WD 21202 #701, Baltimore NOV 1 9 2004 31. Date filed (Month, 32. Registrar's Signature State Registrar

			1 - For State of Ma	ryland / Depa <i>Ce</i>	artment of Health and rtificate of Death	Mental Hygien	
ı	Physici /Medic		1. Decedent's Name (First, Middle, Last) Dong Norris			2. Date of Death Month Division	3. Time of Death
	Examin	er		Vin yrs. last birthday)	4b. City, Town, or Location of Dea If Under 1 Year If Under 24 Hr Months Days Hours Mir	S. B. Date of Birth (Month, Day, Year	
	Director		Usual Residence of Decedent 10a. State 10b. County	59 Yrs.	peation	May 28, 19	945 Maryland 10d. Inside City Limits
	the Maryi 28a-f eho	Director	Maryland Anne Arundel 10e. Street and Number	Baltimo	10f. Zip Code	100.0	1 ☐ Yes 2X No
	3e or		454 Seward Avenue		21225	109.0	U.S.
1036	be filed within 72 hours after death with the Maryland tal Hygiene. Id other then "natural", or Items 23e or 28e-f ehow event, the Medical Examinational be notified at	by Funeral	11. Marital Status 1 Never Married 2 Married 1 Yes 2 Married		Was Decedent of Hispanic Origin? (If Yes, specify Cuban, Mexican, Pue 1 ☐ Yes 25€ No Specify:	Specify Yes or No- rto Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White
9500-91212	filed within 72 ha Hygiene thar then "natu int, the Medical	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5-	(Give	dent's Usual Occupation kind of work done during most of w DO NOT use retired)	orking	Kind of Business/Industry
7	filed w Hygiei othar ti		10th 17. Father's Name (First, Middle, Last)	Ha1	rdresser	me (First, Middle, Maide	eauty Salon
<u>a</u>	should be ind Mental I	To Be	Donald Hunt			ene Gadd	n Sumame)
Maryland	S D E E	-	19a. Informant's Name/Relationship (Type, Print)	19b. Mailir	ng Address (Street and Number or F		or Town, State, Zip Code)
	1 and 2 Health a tam 27 is		Donald Lloyd / Son				aryland 21225
Baltimore,	00		20a. Method of Disposition 1 ☐ Burial 2 🏋 Cremation 3 ☐ Removal from State	1	matory or other place)		Location - City or Town, State
			` 4 □ Donation 5 □ Other (Specify) 21. Signatuper of Funeral Service Licensee	Bayview C			timore, Maryland
n	permit. Departr Importa any injt		France Engineer		001 Ritchie Highw	once Funeral	l Service, P.A. ore, Maryland 21225
	the death certificate be executed Weddical Whe attending physician and and to the attending physician and so as the burial-transit	dlcal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	a consequence of): a consequence of): a consequence of):	: Obstructive	ulmonary	Interval Between Onset and Death
O. BOX 6	aath certif attending for use a:	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome to 1 □ Live birth 2 4 □ Pregnant at 1 9 □ Unknown	2 ☐ Fetal death 3 ☐	Ectopic pregnancy Other (specify)		23d. Date of delivery Month Day Year
cords, P.	The law requires that the do tte has been signed by the page 2 should be detached	þ	Part II. Other significant conditions contributing to death bu	t not resulting in the u	nderlying cause given in Part I.	23e. Did tobacco 1 ☐ Yes 2	use contribute to the cause of death?
He He	The lay ate has page 2	Completed				24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No
V	sicien; certific lirector,	o Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpatier	nt 2 ER/Outpatien	Other	ath (Check only one)	0 Flow (0 - 1)
lon or	Attanding Physicien: r death. ector: After this certific. by the funeral director.	-	27. Mann of Death 1 atural 5 Pending (Month, Day) 2 Accident investigation		-	Home 5 Residence 28d. Describe how inju	
DIVISION	he Hospital or Attanding P n 24 hours after death. he Funaral Director: After ti bietely filled in by the funera	Certification:	3 □ Suicide 6 □ Could not be	ry - At home, farm, str . (Specify)	eet, factory, office	28f. Location (Street a. City or Town, State	nd Number or Rural Route Number, e)
	To the Hosp within 24 hou To the Funal completely fil	Medical	29a. Certifier (Check only one) Certifying Physician: To the best of the best	examination and/or inv	h occurred at the time, date and plac vestigation, in my opinion, death occ	e, and due to the cause(s urred at the time, date an	and manner as stated. d place, and due to the cause(s)
	To the I within 2 To the Complet	Me	29b. Signature and title of certifier Leave C. Wills	m MD	29c. License number D 4 1365	Nova	ate signed (Month, Day, Year) when U, 2004
			30 Name and address of person who completed cause of de George E, Wicks WI II),	301 H05	Printy al Drive, G	len Burnie	MD. 21061
H	Sta Registr		31. Date filed (Month, Day, Year) 32. Registra	r's Signature	P*-		

Amend item#23a-b,PII,25,27,per ME,G837,11/17/04, TT
State of Maryland / Department of Health and Mental Hygiene 36722 1 - State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Neme (First, Middle, Last) Month Physician 31 01sen May 2004 2:20 P M Cathryn Lynn /Medical 4c. County of Deeth 4b. City, Town, or Location of Death 4a. Fecility Name (If not institution, give street and number) **Examiner** Montgomery Washington Adventist Hospital Takoma Park 8. Date of Birth (Month, Day, Year)
Sept. 21,1953 Washington D.C. If Under 1 Year | If Under 24 Hrs.
Months Days Hours Min. 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** 1 ☐ M 2 🂢 F Months 50 Yrs 216-64-7193 Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County item 27 is marked other than "natural", or iteme 23a or 28a-f show other traumatic event, the Mcdical Examinar must be motified at 1 ☑ Yes 2 ☐ No Maryland Montgomery Takoma Park Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20912 United States 6608 Cockerille Ave. death v Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. permit. Peges 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural", or itemeny injury or other traumatic event. The Medical Eventua 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Self Employed Research / Computer 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Olsen, P. Price Arthur Κ. Jr. Marjorie 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Nancy O. Henry / Aunt P.O. Box 99; McDaniel, MD 21647 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State June 7, 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State ' 4 ☐ Donation 5 ☐ Other (Specify) Cedar Hill Cemetery 2004 Suitland, MD 22. Name and Address of Facility
Rapp Funeral and Cremation Services 1400382 23a. Part. Effer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Arteriosclerotic cardiovascular descriptions. 933 Gist Ave., Silver Spring, MD Approximate Interval Between Onset and Death Arteriosclerotic cardiovascular disease Immediete Cause (Final disease or condition resulting in death) Physician Ma /Medical Due to (or as a consequence of) **Examiner** Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last CERTIFICATION APPROVED BY MEDICAL EXAMIN Examiner After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 4 Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Dther significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Records, The law requires 1 Yes 2 No 3 Probably 4 Unknown diabetes mellitus 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed 1 ☐ Yes 2 ☐ No 2 No Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manper of Death 28b. Time of Injury Plospitel or Attending Pl 24 hours after death. Funerel Director: After the Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined within 24 hours after dea To the Funeral Directo completely filled in by th 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D18895 June 1, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) VESTERYOUT PACK, MD2012 LALIM 7610CARROLL A 31. Date filed (Month, Day, Year) 32. Registrar's Signature State oak Registrar

State of Maryland / Department of Health and Mental Hygien 1 - For State Registrar 36723 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Yeer Lois C. Powell 1:15 AM 2004 /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death PITO Rosedale har c 10 04 -more 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday, **Funeral** 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign Months Days 1 □ M 2 🖳 F Hours 80 NorthCarolina Director 220-22-2188 Oct.28,1924 Usual Residence of Decedent with the Maryland 10a, State 10b. County 10c. City, Town or Location item 27 is marked other than "natural", or items 23a or 28a-f ahov othar traumatic event, the Modical Examiner must be rediffed at 10d. Inside City Limits Director MD Baltimore 1 ☐ Yes 2 No Baltimore 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 7333 Straton Way 21224 Funeral USA death 12. Was Decedent Ever in U.S. Armed Forces? Was Decadent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2X No If Yes, Give Year or Dates: by 1 ☐ Yes 2 ☐ No Specify: 3♥ Widowed 4 □ Divorced Specify: White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry and Mental Hygiene. is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Homemaker 12th own home 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname, should be Nathan Hockaday ပ Mamie Tucker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or othar tra Allen Powell son 13 Linwen Way Baltimore MD 21236 20a. Method of Disposition 20b. Place of Disposition (Name of cametery, crematory or other of 20c. Location - City or Town, State Murial 2 ☐ Cremation 3 ☐ Removal from State OakLawnCemetery 11/20/04 Baltimore MD ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility ConnellyFuneralHomeofEssex 300 Mace Ave. Baltimore MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Intumoria disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner the death certificate be executed burial-transi Due to (or as a consequence of): Box 68760 physician Physician/Medical the ası esn IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Year 4☐Pregnant at time of death P.O. I 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 ☐ Unknown the 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, by 2 No 3 ☐ Probably 4 ☐ Unknown Completed 1 ☐ Yes page 2 should 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death? has certificate I 2 No 2□ No 1 🗌 Yes 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 10 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death Aftert 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division To the Hospital or Attending 1 Natural 2 Accident 5 Pending death. investigation Director: , in by the f 1 Yes 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral D Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 10057863 11 Name and address of person who completed cause of death (Item 23a) (Type, Print) Square Dire Baltimore, MD 2/237 1A Ai .H05 0501 31. Date filed (Month, Day, Year) 32. Registrar's Signature State NOV 1 9 2004 Registrar

Amend i tem#23a C,27 Print in Black Indelible Ink TEnsure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 36724 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** August 16:43 25, OSA ARKER 2004 /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner HUnder 1 Year If Under 24 Hrs.
Months Days Hours Mai-8. Date of Birth (Month, Day, Year) Ν Beltimore ot Hospital 9. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** 1 □ M 2 € F ZZO525979 Usual Residence of Decedent Yrs Director 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County s 23a or 28e-f show ust be notified at 1 XYes 2 □ No Director ALT, MORE 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 3514 USA SIDE 21215 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, or Itams 11. Marital Status the Medical Examiner: Black, White, etc. filed within 72 hours after 1 ☐ Never Married 2 ☐ Married 1 Yes 2 No Maryland 21215-0036 Specify Completed by 3 ☐ Widowed 4 ☐ Divorced BLACK "natural" 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) ASSISTANT BALTIMORE GAS & ELECTRIC 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be GREENE Moul TRIE ALVIN 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Belationship (Type, Print) of Health of item 27 I LEVIN Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition ō Important: If it any injury or o once. 1 Burial 2 ☐ Cremation 3 ☐ Removal from State CEMELERY * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Botts ARDING mD. Moura 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Complications of chronic alcoholism Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** hour /Medical Due to (or as a consequence of) Examiner KOLI Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) CERTIFICATION APPROVED BY MEDICAL EXAMINE Examiner physician and s the burial-transit The faw requires that the death certificate be executed Due to (or as a consequence of): O. Box 68760. Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months?
1 Yes 2 No 5 Other (specify) ed by the a 9 TUnknown Division of Vital Records, P. signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Diabetis 3 ☐ Probably 4 ☐ Unknown 1 Yes 2 No peen 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No Diabetes Mellitus page 2 s performed? 1 ☐ Yes 2 ☑ No this certificate To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one. Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 X es 2 Ne 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 After thi 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. 28d. Describe how injury occurred 27 Manner of Death Injury at Work? Certification; Injury 5 Pending 1 Natural 1 ☐ Yes 2 ☐ No death. investigation 2 Accident Director: 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 T Homicide within 24 hours after To the Funeral Dire 10. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier RES-000 Bradeuslicek 25,2004 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BRADAUSKA ITE Hospital Boltinesre 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

PARKER

		Registrar 1. Decedent's Name			arvland/Dep i-f per me Ce	runcate of	Dealli	2. Date of De	ath	004	36725 3. Time of Death
Physicia /Medic			OHN PIS					Novemb	er I	5 , 2004	1305 PM
Examin				ve street and number)		4b. City, Town, o	or Location of Death		4c.	County of Deat	h
			tford Ave			Baltimo				N/A	
Funeral Director		5. Social Security N 219-50-4 Usual Residence of	4699	Sex 7. Ag	e (In yrs. last birthday 54 Yrs.) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da 8 / 2 /	th 19. Year) 50	Co	hplace (State or Foreign untry) RYLAND
show		10a. State	10b. County		10c. City, Town or L	ocation					10d. Inside City Limits
Ba-f si	ctor	MD	N	/ A	BA	LTIMORE					1 Maryes 2 □ No
or 28a-f	Director	10e. Street and Nur		ATTENITIE		10f. Zip Code 212	27.		-	en of What Co	untry?
eath w	Funerai	633 MOI	NTFORD	AVENUE	Ever in U.S. 13			pecify Yes or No		4. Race - Ame	rican Indian.
s I and 2 should be filed within 72 hours after death with the Maryland I Health and Mental Hygiene. A feath and Mental Hygiene is the mass 23e or 28a-f show other treumatic event. It a Medical Examinar must be redified at	þ		ied 2∏ Married 4 ⊠Divorced	Armed Forces?		If Yes, specify Cub 1 ☐ Yes 2 ☑ No	dispanic Origin? (Span, Mexican, Puerto Specify:	Rican, etc.)		Black, White	
natur	eted	(Spec	15. Decedent's E		16a. Dece	edent's Usual Occup	pation during most of work	kina	16b. Kin	d of Business/	Industry
within ne.	Completed	Elementary/Seco	ondary (0-12)	College (1-4or 5	ife.	DO NOT use retire O WORKE	d)		CENE	RAL M	OTOR S
Hygie ther t		17. Father's Name			AUI	O WORKE	18. Mother's Nam				OTORS
Mental Hygi Mental Hygi arked other	To Be	JOSEPI	H JOHN	PISKOR			BETTY	ELIZAB	ETH	WALDO	RSKI
and Mental Hygiene. tamarked other thereforms eumatic event, I's M		19a. Informant's Na	ame/Relationship	(Type, Print)	19b. Mail	ing Address (Street	and Number or Rui	ral Route Numbe	er, City or	Town, State, Z	(ip Code)
m 27		VERONIC		OR		GARDMA		BALTIM			21209
rage ment o ent: If ury or	Committee of the Commit			☐Removal from State	20b. Place of Disp cemetery, cre BAYVIEW	matory or other pla		Date 19/04		I MORE	
Departr Departr Import eny in		21. Signature of Fu	ineral Service Lice	ensee	ĹŔ	ACZOROW	SKI FUNI	ERAL HO	OME	P.A.	
	-	23a, Part1, Enter the	he disease, or cor	pplications that caused y one cause on each li	the death. Do not en	525 FLE	ET ST. I	BALTIMO or respiratory at	ORE,	MD.	21224 Approximate
Itilicate be executed /Medical /Maminer as the burial-transit as the burial-transit	dicai Examiner	Immediate Cause in disease or condition resulting in death) Sequentially list conif any, leading to improve cause. Enter Under Cause (Disease or that initiated events resulting in death) I	nditions, nmediate orlying injury	b. Due to (or as	e intoxicat a consequence of): a consequence of): a consequence of):	cion					Onset and Death
ed by the attending p detached for use as	by Physician/Medic	IF FEMALE: 23b. Was decedent in the past 12 1 ☐ Yes 2 [9 ☐ Unknown	months? ☐No	23c. If yes, outcome 1 □Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal death 3	□Ectopic pregnance □ Other (specify)	/		2:	3d. Date of deliment	very Day Year
en signed b	d by Pl	Part II. Other signif	ficant conditions	contributing to death b	ut not resulting in the (underlying cause giv	ren in Part I.	4	obacco us Yes 2□		the cause of death?
Adending Prysicien: The taw requires that the death certificate refers. The factor: After this certificate has been signed by the attending phys by the funeral director, page 2 should be detached for use as the	Completed							24a. Was autop perio 12 Yes	SV	24b. Were aut prior to c death?	topsy findings available ompletion of cause of
eicien: The certificate h	Be	25. Was case refer examiner?	red to medical				26. Place of Deat		пе)	-/-	
this o	ို	1 XYes 2		Hospital: 1 Inpatie			4 Nursing Ho				ity) At scene
h. After funer	tion	1 Natural	5 Pending investigation	11 [™] 15 [©] 0	4 ^{Year)} 8:45 ^{ury}	M 1 🗆	Vac 2 No	28d. Describe h	iow injury	occurred	
Dir	Certification:	3 Suicide 4 Homicide	6 Could not determine	Lound	found ury - At home, farm, st c. (Specify) home	a	Α	unknown 28f. Location (S City or Tow Baltimor	Street and vn, State)	Number or Rui	Montford A
4 hours Funere	edical (29a. Certifier (Check only	1 Certifying P	hysician: To the best	of my knowledge, dea f examination and/or in	th occurred at the tire	ne, date and place,	and due to the	cause(s) a	nd manner as	stated.
To the Hospital within 24 hours a vithin 24 hours to the Funerel completely filled	Med	one) 29b. Signature and		and manner sta	ated.	29c. Licens				signed (Month	
		1		112							
To Cor		1//	A 11			O.C.	M.E.				

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No 2. Date of Death 1. Decedent's Name (First, Middle, Last) - 1<u>7,</u> Month **Physician** 2004 5:30 Paniccia November /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner N/A Baltimore City Esters Place Assit Living If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) October 17, 1915 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Funeral 1**∑**M 2□ F 89 Director 108-10-7986 New York Usual Residence of Decedent filed withIn 72 hours after death with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits tem 27 is marked other than "natural", or itama 23a or 28a-f show other traumatic event, the Medical Examinar must be nutillised at 1 XYes 2 □ No Md. Baltimore City N/A Direct 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 6014 Prescott Ave. 21212 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: White β If Yes, Give Year or Dates: 3 Widowed 4 XDivorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Pages 1 and 2 should be filed withln nent of Health and Mental Hygiene. Int: If Itam 27 Is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Fed. Gov't 9 yrs. Machinist 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Nazzareno Paniccia 2 Elsie Yebonni 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Grandson Brian Paniccia 6014 Prescott Ave. Balto. Md. 21212 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Nov. 22 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State ō permit. Page Department of Important: If any injury or 2005e. Schenectady N.Y. John the Baptist C. * 4 ☐ Donation 5 ☐ Other (Specify) C. 2004 22. Name and Address of Facility 21. Signature of Funeral Service License Connelly Funeral Home Of Dundalk 7110 Sollers Point Rd. 7110 Sollers Point Rd. 21222 not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part1. Enter the disease, or complications that caused the death, shock, or heart failure. Lift only one cause of each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) tosto **Physician** /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-transit attending physician and for use as the burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) the detached 9 Unknown 9 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ should be 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 certificate has autopsy 1 ☐ Yes 2 ☐ No 2. No director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 1 ☐ Yes 2 No 2 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 ther (Specify) this filled in by the funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? s after death. Certification: or Attanding 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely within 2. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number SID 30. Name and address of person who completed cause of death (tem 23a) (Type, Print) Baltinoge, ALIDA ANDRIOLLO-ESPINOZ 32. Registrar's Signature 31. Date filed (Month, Day, Year) NOV 1 9 2004 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1 Decedent's Name (First, Middle, Last) Month **Physician** 18 November 2004 Placek Maggio Marv /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Catonsville Forest Haven Nursing Home If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Days Hours Months 1 □ M 2 🗓 F 213-16-3077 81 Nov. 19 1922 Maryland Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a State ns 23c or 28a-f show 1 ☐Yes 2 ☐ No Director Baltimore Maryland NA 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. 21224 404 Imla Street Completed by Funeral Pages 1 and 2 should be filed within 72 hours after death v nent of Health and Mental Hygiene. ant: If Item 27 is marked other than "natural", or Items 23 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? ☐Yes 2X No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: If Yes, Give Year or Dates: Specify: 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 8'th Independent Can Co. NA Cutter on the Line 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Maggio Josephine Joseph Unknown 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 6721 Dabville Avenue Baltimore, Maryland 21222 (Daughter JoAnn Weber 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Department of H Important: If Ite any injury or oti once. November 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Dundalk, Maryland Sacred Heart of Jesus * 4 ☐ Donation 5 ☐ Other (Specify) 22,2004 21. Signature of Funeral Service Licenses W. Dabrowski/Chojnacki Funeral Homes P.A. ank 1005 Dundalk Ave. Baltimore, Maryland 21224 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one gause on each line. Approximate Interval Between Onset and Death CEREBRO VASCULAR Immediate Cause (Final disease or condition resulting in death) THEROSCHEROTIC Physician /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine physician and the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): 68760. Physician/Medical IF FEMALE Box 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☑ No 5 ☐ Other (specify) 4☐Pregnant at time of death the o 9 Unknown þ ۵ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, þ 1 Yes 2 No 3 Probably 4 ⊋Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy performed: 1 Yes 2 No Division of Vital To the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home Hospital: 1 ☐ Inpatient 1 ☐ Yes 2 ☐xNo 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) 2 this 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of After t Certification: 1X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident Director: 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 - Homicide after 24 hours a To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier cal (Check only one) the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 0 28591 vairou t 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

Tasneem

Lakhani M.D.

1 9 2004

Registrar's Signature

7220 Park Heights Avenue Baltimore, Maryland 21208

			1 - For State Registrar	tate of Maryland / D	epartment of F Certificate of			iene og. No. 200	4 36728
	Physici	an	1. Decedent's Name (First, Middle, Last) Robert Robedee				2. Date of Death Month	Day Yeer	3. Time of Death
	/Medic		4a. Facility Name (If not institution, give street	at and number)	4b. City, Town, o	or Location of Death	October	27, 2004 4c. County of Dea	th
		Ŭ.	3114 Adderly Court			Spring	T	MONTGOM	
ı	Funeral Director		5. Social Security Number 102–18–3070 6. Sex	7. Age (In yrs. last birth	nday) If Under 1 Year Months Days	Hours Min.	Septembe	9. Bir er30,23 Ne	thplace (State or Foreign ountry) W York
	D		Usual Residence of Decedent		11		-		
	Aarylar f show	ō	10a. State 10b. County	10c. City, Town Silver					10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	r 28a-	irect	Maryland MONTGOMERY 10e. Street and Number	SIIVEI	10f. Zip Code		10	og. Citizen of What Co	ountry?
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36	in 72 hours aftar death with the Maryland "natural", or items 23e or 28e-1 show 'estical Exercites must be notified at	by Funeral Directo	Married 2☐ Married	Was Decedent Ever in U.S. Armed Forces? I □ Yes 2 □ No If Yes, Give Year or Dates:	13. Was Decedent of I If Yes, specify Cub 1 ☐ Yes 2 🛣 No		pecify Yes or No- o Rican, etc.)	14. Race - Ame Black, Whi	te, etc.
21215-0036	2 hour		15. Decedent's Education	on 16a.	Decedent's Usual Occup (Give kind of work done	pation	tina	16b. Kind of Business	
121	d within 7 giana. ir than "n I're Medi	Completed		College (1-4or 5+)	life. DO NOT use retire	d)	King .	Judicial	Cwatom
d 21	Hygi thar int.		12 17. Father's Name (First, Middle, Last)		Court Office		ne (First, Middle, M		System
ılan	2 should be and Mantal is marked o	To Be	Alexander Robedee			Mildre	d Blank		
Maryland	s 1 and 2 should f Haaith and Man Itam 27 is marke other traumatic		19a. Informant's Name/Relationship (Type,		Mailing Address (Street				
	is 1 and 20 Haalth itam 27 i		Dr. Gary O. Trotter 20a. Method of Disposition	20b. Place of	14 Emmet Ro			g, MD 2090 20c. Location - City or	
altimore,	Pages ant of nt: if it ry or o		1 Burial 2 Cremation 3 Remo	oval from State	v, crematory or other pla .ncoln Crema			Brentwood	, MD
Balti	permit. Pagas i Dapartmant of H important: if Ita any injury or ot once.		21. Signature of Funeral Service Licensee					ldi Funera ; Silver S	l Home, Inc. pring, MD
П			23a. Party. Enter the disease, or complicati shock, or heert failure. List only one c	ons that ca <i>u</i> sed the death. Do no ause on each line.	ot enter the mode of dyi	ng, such as cardiac	or respiratory arre	st,	Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	Cardiac Arythi	mia				
ŀ	Examiner		Commence the line was distance.	Coronary Arte:					
	pg tis	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence o					
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eco	law as b	Completed					24a. Was an	24b. Were at	utopsy findings available completion of cause of
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)	Withi Total	Me	29b. Signature and title of certifier	1 State	29c. Licens	2038	0	od. Date signed (Mont November	
	10		30. Name and address of person who comp	eted cause of death (Item 23a) (MOVEMBEL .	2004
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	Sta Registr		31. Date filed (Month, Day Year)	32. Registrar's Schature	and I				

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1 Yes 2 No 3 Probably 4 Unknown	7.	that the ed by detac	а.		stributing to death but not resu	ulting in the u	nderlying cause giv	en in Part I.	23e. Did tob	acco use contribut	e to the cause of death?
24a. Was an autopsy performed? 1 Yes 2 Manner of Death 1 Matural 5 Pending investigation 1 Yes 2 Mo 27. Manner of Death 1 Matural 5 Pending investigation 3 Suicide 4 Homicide 4 Homicide 4 Homicide 4 Homicide 4 Homicide 5 Residence 6 Could not be building, etc. (Specify) 28. Date of Injury At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) 29b. Signature and title of celtifier 29b. Signature 29b. Signature 30b. Name and address of person who completed cause of death (Item 23a) (Type, Print) 29c. License number 29d. Date signed (Month, Day, Year) 32 Registers Signature 30b. Name and address of person who completed cause of death (Item 23a) (Type, Print) 22b. State 31. Date filed (Month, Day, Year) 32 Registers Signature 32b. Signature	2	eq eq	d b						1 □ Ye	s 2 1 No 3	Probably 4 Unknown
25. Was case referred to medical examiner? 1 Yes 2 No 25. Was case referred to medical examiner? 1 Yes 2 No 26. Place of Death (Check only one) 27. Manner of Death 1 Matural Nursing Home Residence Residen	3	_ D 78	ojete							24b. Were	autopsy findings available
25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) B 2. TM CM. The state of the control of the	r	o	шо						perform	ied? death	1?
Yes 2 No 1 Yes 2 No 2		ien: rtifica ctor, p	O					26. Place of Deat		-	
1 Matural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Aural Route Number, City or Town, State) 29a. Certifier (Check only one) 29a. Certifier (Check only one) 29b. Signature and title of certifier 29b. Signature and title of certifier 29b. Signature and ditte of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 22 S. Green St., Baltimore, Md. 31. Date filed (Month, Day, Year) 32. Pegistar's Signature 4 State > =	hysic his ce	.0	1 ☐ Yes 2 ☐ Mo	1 Inpatient 2		it 3 DOA	4 Nursing Ho			Specify) BROTHERE	
29a. Certifier (Check only one) 29b. Signature and dittered of title of certifier (Check only one) 29b. Signature and dittered cause of death (Item 23a) (Type, Print) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) State 31. Date filed (Month, Day, Year) 32. Registrar's Signature & Appendix A		ing P	iuol:	1 ☐Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)		Wor	rk?	28d. Describe ho	w injury occurred	
29a. Certifier (Check only one) 29b. Signature and dittered of title of certifier (Check only one) 29b. Signature and dittered cause of death (Item 23a) (Type, Print) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) State 31. Date filed (Month, Day, Year) 32. Registrar's Signature & Appendix A	2	death death ctor: /	icat	3 Suicide 6 Could not be	28e. Place of Injury - At ho	me, farm, sti		163 2 110			Rural Route Number,
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PARA DARWIN W 22 S., Green St., Baltimore, Md. State 31. Date filed (Month, Day, Year) 32. Registrar's Signature	5	after after Direction by	ertif	4 - Homicide determined	building, etc. (Specif)	1)	,,,		City or Town	, State)	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 22 S. Green St., Baltimore, Md. State 31. Date filed (Month, Day, Year) 32. Flegistrar's Signature		lospite hours unerel	caic	29a. Certifier 1 Certifying Phys	sician: To the best of my kno	wledge, deat	h occurred at the tir	me, date and place,	and due to the ca	use(s) and manner	r as stated. due to the cause(s)
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PARA DARWIN W 22 S., Green St., Baltimore, Md. State 31. Date filed (Month, Day, Year) 32. Registrar's Signature		the I	Medi	one)	and manner stated.						
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 22 S. Green St., Baltimore, Md. State 31. Date filed (Month, Day, Year) 32. Fegistra's Signature		7 ½ ½ Ç		July Signature did title of Catholic) CIAMA M	110	NI	12781		11/19/	oc/
State 31 Date filed (Month, Day, Year) 32 Figistra's Signature & Sports	,	10		30 Name and address of person who or			Print)	10101		11111	
		1'		Pathe I			2 S. Gre		altimore	, Md.	
					- he capear	ture &	poork				

State of Maryland / Department of Health and Mental Hygiene 36730 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 16, 2004 Month **Physician** November Eugene Roberts 3:15 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Anne Arundel Medical Center Annapolis Anne Arundel 8. Date of Birth (Month, Day, Year) May 29, 1927 If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 (\$\frac{1}{2} M 2 □ F 374-22-5305 Michigan Director Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other then "naturel", or Items 23a or 28a-f show treumatic evant, "19 Medical Examinations to motified at 1 ☐ Yes 2 ☐ No Director Maryland Queen Annes Stevensville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 102 South Carolina Road 21666 U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours atter c Department of Health and Mental Hygiene. Importent: If Item 27 is marked other then "naturel', or Iten any injury or other treumatic evant, the Medical Exam. 2016. Black, White, etc. 1 ☑Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: by Specify: White 3 NWidowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Soldier U.S. Military 8 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Julia Rodabaugh Clifford Roberts 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Diana Harper (Daughter) 102 S. Carolina Road, Stevensville, Md. 21666 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Holly Hill Mem. Gar. Nov. 22, 2004 Baltimore, Maryland * 4 □Donation 5 □ Other (Specify) 22. Name and Address of Facility
Bruzdzinski Funeral Home, P.A.
1407 Old Eastern Avenue, Essex, Maryland 21221 1. Signature of Janeral Service Licensee 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) eumoni **Physician** /Medical Examiner ulopal Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last burial-transit ed by the attending physician and detached for use as the burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed 2 No 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physicien: within 24 hours after death.

To the Funerel Director: After this certifica Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 2 | N Other: 1 Inpatient ပ 1 🗌 Yes 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) filled in by the funeral dir 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 2 □No 1 Tes 2 Accident 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 | Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier ARUNDEL MEDICAL CENTER, ANNAROLIS 30 Name and address of person who complete and address of person who completed cause of death (Item 23a) (Type, Print) Anne 37. Registrar's Signature MOV 1 9 2004 31. Date filed (Month, State Registrar

			For 1 _ State	State of Maryland /	Department of Health ar	nd Mental Hygie	2004	36731
			Registrar 1. Decedent's Name (First, Middle, Last		Certificate of Death	Reg.	NE- UU-4	3. Time of Death
	Physici		ANNIE L	Kobinson			Day 2 Year	112:10 PM
	/Medio Examir		4a. Facility Name (If not institution, give		4b. City, Town, or Location of I	Death	4c. County of Death	1
			6812 Sturbr	idge Drive	Baltimoi	re		10re
	Funeral Director		5. Social Security Number 6. Se	7. Age (In yrs. last b		Min. 8. Date of Birth (Mosth, Day, Ye	ar) 9. Birth	nplace (State or Foreign
	ס		Usual Residence of Decedent	47		0 /5 /	1933	/· C
	show	_	10a. State 10b. County	10c. City, Tov	vn or Location			10d. Inside City Limits 1 XYes 2 □ No
	the Ma	ecto	10e, Street and Number	nore Ba	10f. Zip Code	100	Citizen of What Cou	
	with With	5	100. Street and Number	ridge Driv	P D1234	Tog.	III C D	andy:
	death	Funeral Director	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin If Yes, specify Cuban, Mexican, F	? (Specify Yes or No-	14. Race - Amer	
98	72 hours after death with the Maryland natural; or Items 23e or 28e-f show dical Evar: il at trust be rediffed at	y Fu	1 Never Married 2 Married	1 ☐ Yes 2 XNo If Yes, Give	1 Yes 28 No Specify:	-ueno rican, etc.)	Black, White	, etc.
5-0036	hours fural'	ed by	3 Widowed 4 Divorced 15. Decedent's Edu	Year or Dates:	Decedent's Usual Occupation	16h	. Kind of Business/h	Modustry
215	within 72 ene. then "ne	Completed	(Specify only highest grad	e completed) College (1-4or 5+)	Decedent's Usual Occupation (Give kind of work done during most of lifey DO NOT use retired)	f working	_	/ -/
2	filed with Hygiene. other ther	Com	12	0	House Reeper		Jomest	TC
Maryland	ould be fill Mental H arked oth atic even	Be	17. Father's Name (First, Middle, Last)	2001/160	18. Mother's	Name (First, Middle, Maid	fen Sumame)	Lo
Ž	should and Men Is marks sumatic	ဥ	19a, Informant's Name/Relationship (Ty	ner Ville	b. Mailing Address (Street and Number of	or Rural Route Number, Cit	ty or Town, State, Z	ip Code)
Z	and 2 salth ar		Ms. Patricia Robi	NSON	1319 Limit AU	e Baltimo	ore me	1 21239
Baltimore,	es 1 an of Heal f Item 2 r other		20a. Method of Disposition 1 □ Surial 2 □ Cremation 3 □ F	eamata	of Disposition (Name of gry, crematory or other place)	Date 20c	. Location - City or T	own, State
Ei m	ment of tant: If It		`4 Donation 5 □ Other (Specify)	Ced	as Hill	1-23-2004	-len Bu	irnie md
Bal	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Items 23e or 28e-1 show any highry or other traumatic event, If a Medical Ever it at mast ke relified at ODGs.		21. Signature of Funeral Service Licens	"L' Russ	22. Name and Address of Facility	SFuneral	Home	2/2/1
			23a. Party Enter the disease, or complete shock, or heart failure. List only or	ications that caused the death. Do	not enter the mode of dying, such as ca	rdiac or respiratory arrest,	115. 112	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition		MA OF UTARUS			Onset and Death
1	/Medical Examiner		resulting in death)	Due to (or as a consequence				
		er	Sequentially list conditions,	Due to or as a consequence	of):			
Vii	outed nd ransit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events					
, 0,	eath certificate be executed attending physician and for use as the burial-transit	Exc	resulting in death) Last	Due to (or as a consequence	of):			
68760,	physic physic the b	edical		J				
Box (nding use as		IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of pregnancy			23d. Date of deliv	ery
	The law requires that the death certif Ite has been signed by the attending page 2 should be detached for use a	Physician/M	in the past 12 months?	1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		Month	Day Year
P.0	res that the de signed by the a be detached f	Phy	9 ☐ Unknown Part II. Other significant conditions con		in the underking enum grown in Deat I	22a Did tahasa	co use contribute to t	the assume of death?
ds,	signe d be c	d by	Part II. Other significant containers con	inibuting to death but not resulting	in the didentying cause given in Part I.	1 ☐ Yes	2 No 3 Prof	
Records,	w requires been si should	lete				24a. Was an	24b. Were auto	opsy findings available
Re	The la	Completed				autopsy performed	death?	opsy findings available ompletion of cause of
Vital	ctan: ertifica sctor, p	Bec	25. Was case referred to medical examiner?			Death (Check only one)		
of \	ding Physician: The lav h. After this certificate has funeral director, page 2	- To	1 Yes 2 No	fospital: 1 ☐ Inpatient 2 ☐ ER/O 28a. Date of Injury 28b.		ng Home Residence		(y)
on	Attending ir death. ector: After by the funer	tlon	Natural 5 Pending 2 Accident investigation		Time of lnjury at Work? M 1 ☐ Yes 2 ☐ No		ijary occurred	
Division	Attendiuser death.	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, for building, etc. (Specify)	arm, street, factory, office	28f. Location (Street City or Town, Str		al Route Number,
Ö	urs afte ral Dire							
	To the Hospital or Attent within 24 hours after deatl To the Funeral Director: completely filled in by the	Medical	29a. Certifier (Check only one) Certifying Physical Cartifying Ph	sician: To the best of my knowledg ner: On the basis of examination ar and manner stated.	e, death occurred at the time, date and p nd/or investigation, in my opinion, death o	place, and due to the cause occurred at the time, date a	(s) and manner as s and place, and due t	stated. o the cause(s)
	To the Company of the	Σ	29b. Signature and title of certifier	W. Willen, 2	29c. License number	6 (Date signed (Month,	Day, Year)
	1		30. Name and address of person who on the control of the control o	impleted cause of death (Item 23a)	(Type, Print) NORTH CALVALT S	TARGT DAIS	Trained 1	mol 21218
	Sta	-	MCRAG W- W. 1 31. Date filed (Month, Day, Year)	32. Registrar's Signature	A CHESTAL TO THE PROPERTY OF T	1 1	inun	VICI VIVIO
	Registr	ar	119 V 1 9 200	14 Geneva	5 for			

			For Stata Registrar	State of Ma		artment of I		d Mental Hyg	giene ag. N2 0 0 4	36732
ī	Physica	an '	Decedent's Name (First, Middle, Las					2. Date of Dea Month	Day Y Year	3. Time of Death
	/Medic Examin	al -	4a. Facility Name (If not institution, give	REID street and number)		4b. City, Town, o	or Location of D	Death Och Compa	4c. County of Deat	. 8·35 · ···
	Examin	er	NORTHWEST HOSPI				LLSTOWN		BALTIMO	
	Funeral Director		217 12 0000	7. Age ☐ M 2 ☐ F	(In yrs. last birthday 82 Yrs.	Months Days	If Under 24 Hours	Hrs. 8. Date of Birth (Month, Day 4-25-1		nplace (State or Foreign untry) RYLAND
	land ow		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or L	ocation				10d. Inside City Limits
	Marylan a-f show	tor	MD. N/A		BALTIMO	DRE				1 XYes 2 No
	vith the	Direc	10e. Street and Number 3028 ESSEX RD.			10f. Zip Code 2120	7	1	0g. Citizen of What Co USA	untry?
	ns 236	erai	11. Marital Status	12. Was Decedent E	ver in U.S. 13			? (Specify Yes or No-		rican Indian,
36	72 hours after death with the Maryland Instural; or Items 23e or 28e-f show disst Examinet mast be notified at	Completed by Funeral Director	1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced	Armed Forces? 1 ☐ Yes 2√7 N If Yes, Give △	lo	If Yes, specify Cub 1 ☐ Yes 2☐No	an', Mexican', P Specify:	? (Specify Yes or No- ruerto Rican, etc.)	Black, White	
8	tural	ed b	15. Decedent's Ed	Year or Dates:	16a. Dec	edent's Usual Occu	pation		16b. Kind of Business/	
21215-0036	within 72 ene. then "ne re Maglis	nplet	(Specify only highest gra-	de completed) College (1-4or 5-	(Giv	e kind of work done DO NOT use retire	during most of d)			
	filed wi Hygien other th		-12-	-1-	FOOI	SERVICE		ISOR Name (First, Middle,	NURSING	CENTER
lanc	and be fill fental Friked of	To Be	17. Father's Name (First, Middle, Last) NORMAN A. CAMPI	BELL				NETTE COOM		
Maryland	and 2 should ealth and Men n 27 Is marke ter treumatic		19a. Informant's Name/Relationship (7 INEZ YARBOROUGE			ing Address (Street BO28 ESSE	and Number of X RD. B	ALTIMORE,	r, City or Town, State, Z MARYLAND 2	(ip Code) 1207
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Importement of Health and Mental Hygiene. Importement if item 27 is marked other then "natural", or items 23a or 28a-1 show amy injury or other treumatic event, it a Madical Examinationals be notified at any injury or other treumatic event, it a Madical Examinationals be notified at any once.		20a. Method of Disposition 1 XBurial 2 Cremation 3 C 4 Donation 5 Other Specify	Removal from State	20b. Place of Disp cemetery, cri BALTIMORI	ematory or other pla			20c. Location - City or ALTIMORE,	
Balti	permit. Departm Importe any inju			See ONATHAN					UNERAL HOM	
	Physician		23a. Part1. Enter the disease, or companies the disease, or companies the disease or condition. Immediate Cause (Final disease or condition.	olications that caused one cause on each lin	the death. Do not ene.	nter the mode of dyi	•	rdiac or respiratory arr	est,	Approximate interval Between Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a	a consequence of):	1				
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as a	a consequence of):	Lung	<u>Co</u>	ncor		
	be executed ician and burial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or as a	a consequence of):					
8760,	eath certificate be executed attending physician and for use as the burial-transit	icai		d						
9	entifica ding ph	/Med	IF FEMALE:	23c. If yes, outcome	of pregnancy				20d Date of deli	
.O. Box	D 0 D	Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal death 3	□Ectopic pregnand □ Other (specify) _	у		23d. Date of deli Month	Day Year
Δ.	S 5 0	by Ph	Part II. Other significant conditions of	ontributing to death bu	ut not resulting in the	underlying cause gr	ven in Part I.	23e. Did to	bacco use contribute to	
ecords,	w require been sig should b	ted						1Y	es 2□No 35 Pro	obably 4 Unknown
$\mathbf{\alpha}$	The larate has	Completed						24a. Was a autops perfori	sy prior to d	topsy findings available completion of cause of 2 No
Vital	Physicien: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:		Ott		Death (Check only or	*	
of	Phys this ral dia	1: To	1 Yes 2 No 27. Manner of Death	28a. Date of Injur	y 28b. Time	III JU DOA			ence 6 Other (Spec	eify)
ion	Attending F r death. ector: After by the funer	ation	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day	Year) Injury		rk?]Yes 2⊟No			
Division	or Attendate death Director: /	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injubulding, etc	ury - At home, farm, s c. (Specify)	treet, factory, office		28f. Location (Si City or Town	treet and Number or Ru n, State)	ral Route Number,
_	To the Hospital or Attendwithin 24 hours after death To the Funeral Director:	edical C	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exam	ysician: To the best of niner: On the basis of and manner sta	examination and/or i	th occurred at the t nvestigation, in my	ime, date and p opinion, death	place, and due to the coccurred at the time, d	ause(s) and manner as late and place, and due	stated. to the cause(s)
	To the within 2 To the comple	Me	29b. Signature and title of certifier	mest	a mo	29c. Licen	se number		19d. Date signed (Month	Day, Year)
	h		30. Name and address of person who	completed cause of de	eath (Item 23a) (Type	Print) Je Co	NOER 1			
			420111111111111111111111111111111111111		MTER !	RAHOAU	STULH	mo :	31133.	
	Sta Regist		31. Date filed (Month, Day, Year) NQV 1 9 20		ar's Signature	-				
	do in			1	A	1000				

DHMH 17 Rev 1/2001

ORIGINAL

				Department of Health and Mental Hygiene Certificate of Death Reg. No. 2004 36733
	Physici		1. Decedent's Name (First, Middle, Last) Phillip Sheets	2. Date of Death Month Day Year 1705 M
	/Medio Examir		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death Ac. County of Death Baltimore
	Funeral Director		5. Social Security Number 6. Sex AM 2 F 7. Age (In yrs. last b) 47 Usual Residence of Decedent	birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min. Yrs. Months Days Hours Min. June 20, 1957 West Virginia
	Maryland 9-f show	tor		own or Location 10d. Inside City Limits 1 □ Yes 2 No
99	within 72 hours after death with the Maryland ene. then "natural", or Items 23a or 28e-f show ta Medical Exercit ar final be ricitled at	by Funeral Director	10e. Street and Number 23123 Bass St. 11. Marital Status 1 □ Never Married 2營 Married 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 灣子No If Yes, Give	10f. Zip Code 23487 13. Was Decedent of Hispanic Origin? (Specify Yes or Nolif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1□ Yes ☒☒No Specify: White 10g. Citizen of What Country? USA 14. Race - American Indian, Black, White, etc. Specify: White
21215-0036	vithin 72 hours ne. hen "natural" e Medicel Ex	Completed b	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	6a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry
Maryland 21	ould be filed with Mental Hygiene. Brked other the latic event, Ive I	To Be Col	17. Father's Name (First, Middle, Last)	rounds worker Loudon Park Cemetery 18. Mother's Name (First, Middle, Maiden Sumame) Donna June Adkins
Baltimore, Mary	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hyglene. Important: If item 27 is marked other then "natural", or Items 23a or 28e-f show any injury or other treumatic event, If a Medical Exercities in a file of once.		19a. Informant's Name/Relationship (Type, Print) Nora L. Sheets - Wife 20a. Method of Disposition 1 □ Burial 2 ☑ Cremation 3 □ Removal from State	9b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 23123 Bass St., Windsor Virginia 23487 of Disposition (Name of Nov. 20, 2004 Nov. 20, 2004 nore Crematory @ Baltimore Maryland 22. Name and Address of Facility Loudon Park Funeral Home 3620 Wilkens Ave. Baltimore, Maryland 21229
	Proyected / Medical Examiner	Examiner	23a. Part1. Enter the disease, or complications that caused the death. Do shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence cause. Due to (or as a consequence cause).	e my o Cardial Infundin 1632-1705 1001).
.O. Box 68760	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	by Physician/Medicai	d. IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 \(\text{Yes} \) 2 \(\text{No} \) 8 \(\text{Unknown} \) Unknown	
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Vital Re		Be	mer - Abdominoperioleal res 25. Was case referred to medical example? Hospital:	autopsy performed? Question
Division of	ing Phye	Certification; To	1 Le res 2 No 1 Le inpatient 2 ER/C	Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) D. Time of Injury M 28c. Injury at Work? M 1 Yes 2 No 28f. Location (Street and Number or Rural Route Number, City or Town, State)
	To the Hospital or Attenc within 24 hours after death To the Funeral Director: completely filled in by the	Medical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge (Check only one) 1 Medical Examiner: Of the basis of examination a cumanner state.	lge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
	withi Tot com	M) Jaw Jund	29c. License number 29d. Date signed (Month, Day, Year) 11/16/2004
	Sta	ato.	30. Name and address of person with completed cause of death (Item 23a Jean - Albert Mi D 31. Date filed (Month, Day, Year) 32. Registrar's Signature	MD 10 N payson street Balline Md 2123
	Regist		NOV 1 9 2004	book

DHMH 17 Rev 1/2001

ORIGINAL

			1- State of Maryland / Department of Facilities Certificate Certific	Dooth	gie 2e 0 0 4 3 6 7 3 4 Reg. No.
185	Physici /Medic		1. Decedent's Name (First, Middle, Last) James Staulei	2. Date of De Month	Day Year 2 20 p M
	Examir Funeral Director	er	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Rose Manner Assisted Living Balfa 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year Months Days UN Now 1 159 M 2 F 98 Yrs.	or Location of Death MOTECLY If Under 24 Hrs. Hours Min. 8. Date of Bir (Month, Da	4c. County of Death Relfmere Cery th ay, Year) 9. Birthplace (State or Foreign Country) VA
	Aaryland I show	ō	10a. State 10b. County 10c. City, Town or Location		10d. Inside City Limits 1 ∰ Yes 2 □ No
	with the h or 28e-1 be notiff	Director	10e. Street and Number 10f. Zip Code		10g. Citizen of What Country?
336	be filed within 72 hours after death with the Maryland that Hygliene. 3d other then "neturel", or Items 23e or 28e-f show event. The Medical Examinat must be notified at	by Funeral	3300 Alto Rd. 2121 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 2 No 2 No 2 No 2 No 2 No 2 No 2 No 2 N	lispanic Origin? (Specify Yes or No an, Mexican, Puerto Rican, etc.) Specify:	14. Race - American Indian, Black, White, etc. Specify: Black
Maryland 21215-0036	d within 72 hou giene. or then "neture Ire Medical E	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) UN Whow N	during most of working d)	16b. Kind of Business/Industry
ryland	2 should be filed vand Mental Hygie Is marked other to eumatic event. It	To Be C	17. Father's Name (First, Middle, Last) William Staulei	18. Mother's Name (First, Middle,	, Maiden Surname)
Baltimore, Ma	iges 1 and at of Health if item 27 or other tr		Carla Ransom Guardian 10 N. date of Disposition (Name of cemetery, crematory of other plants of the	St. Baltis	20c. Location - City or Town, State
Balti	permit. Pa Departmen Important eny injury		21. Signature of Funetal Service Licensee 22. Name and Addre	orty Heights	Catonsuille MD Funeral Home Ave. Balto MD 21207
68760,	Iticate be executed //Medical Examiner s the burial-transit	edical Examiner	shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): C. General 2 ed Caffie of the properties of the consequence of the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): C. General 2 ed Caffie of the consequence of the cause (Disease or injury that initiated events resulting in death) Last	asi osclerosus	rrest, Approximate Interval Between Onset and Death
P.O. Box 68	death certi e attending id for use a	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	′	23d. Date of delivery Month Day Year
	law requires that the as been signed by th 2 should be detache	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause give Cen brad Dysphagea		obacco use contribute to the cause of death? Yes 2 No 3 Probably 4 Unknown
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Division	el or Attences after death	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (S City or Tow	Street and Number or Rural Route Number, vn, State)
	To the Hospitel or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	edical	29a. Certifier (Check only one) Certifying Physicien: To the best of my knowledge, death occurred at the tire of the basis of examination and/or investigation, in my cand manner stated.	ne, date and place, and due to the opinion, death occurred at the time, o	cause(s) and manner as stated. date and place, and due to the cause(s)
)	To the I within 2 To the I complet	W	29b. Signature and Little of certifier 29c. Licens Delta Lo		29d. Date signed (Month, Day, Year) NOV 18 2004
	7	-	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DN MOGES GEBSE MASIAW 4660 Will	Kens Are Bres	NOV 18 2004 eto Md 21229
5.	Sta Registr		31. Date filed (Month, Day, Year) (32. Registrar's Signatus) (32. Registrar's Signatus)		

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Month Year Pete W. Standifer 1:30 AM 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 3707 W. Franklin Street Balto If Under 24 Hrs. Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year Months Days 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1**∑**M 2□F Director Yrs 445-18-5078 80 12-25-1924 0klahoma Usual Residence of Decedent with the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits in than "natural", or Itams 23a or 28a-f show the Medical Exampler must be indiffed at 1 Yes 2 □ No Director Md N/A Balto 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3707 W. Franklin Street 21229 Funeral USA filed withIn 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify **Black** Completed by 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Longshoreman al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Merchant Seaman 12th grade N/Aother traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be filt Department of Health and Mental Hinportant: If Item 27 is marked oth any liquy or other traumatic event once. Be ပ Jim Standifer Zader Hankins 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Brian Turner - Nephew 4310 Mary Ridge Drive Randallstown, Md 21133 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State NBurial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) Garrison Forest Vet 11-23-2004 Owings Mills, Md 21. Signature of Funeral Service Dicenses 22. Name and Address of Facility March F/H 4300 Wabash Avenue Balto, Md 21215 23a. Part . Enter the disease, or complications that caused the demh. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final pertensive Atherosclerosis **Physician** disease or condition resulting in death) 2 years /Medical Due to (or disconsequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) **Examiner** The law requires that the death certificate be executed use as the burial-transit that initiated events resulting in death) Last attending physician and Due to (or as a consequence of): Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? Live birth 2 Fetal death 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (specify) been signed by the a should be defached f 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Abdominal Aortic Aneurysm 1 X Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Failure 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 performed Hypertension
25. Was case referred to medical 1 ☐ Yes 2 ☐ No 1 Yes 2 No or Attending Physician: director. 26. Place of Death (Check only one) Hospital: Other: 1 Yes 2 No Medical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 KResidence 6 ☐ Other (Specify) fhis 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Affer 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A investigation 2 Accident filled in by the 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 T Homicide To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Sandya Marshall BVAMC 10 N, Greene St. Baltmore, MD 2/201 Sandra Marshal 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar NOV 1 9 2004

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

P.O. Box 68760,

Division of Vital Records,

State of Maryland / Department of Health and Mental Hygieney 36736 Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Nina Scott **Physician** 4:45 A.M November 15 2004 /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Fecility Name (If not institution, give street and number) **Examiner** Genesis Eldercare Hammonds Lane Anne Arundel Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🗙 F Yrs. 212 30 7809 70 Maryland Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland nent of Heatth and Mental Hygiene. Int if Itam 27 is marked other than "natural", or Items 23s or 28s-1 show 10d. Inside City Limits 10b. County 10c, City, Town or Location items 23a or 28a-f ahow Iner must be notified at 1X Yes 2 □ No N/A Baltimore Be Completed by Funeral Director Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 1622 Popland Street 21226 U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11, Marital Status Bleck, White, etc. the Medical Executors 1 □ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Marned Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White 3 ☐ Widowed 4 X Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 12th 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) (not available) (not available) 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 Department of Health at Important: if Itam 27 is any injury or other trat once. Mary E. Scott 1622 Popland Street Baltimore, Maryland 21226 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 11/17/2004 Bayview Crematory Baltimore, Maryland ^ 4 □Donation = 5 □ Other (Specify) 22. Name and Address of Facility Gonce Funeral Service, P.A. 21. Signature of Funeral Service Licensee 4001 Ritchie Highway Baltimore, Maryland 21225 Cione manualle 23a. Pent. Enter the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, speck, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Jementif **Physician** FNA /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner physician and s the burial-transit law requires that the death certificate be executed Due to (or as a consequence of): Box 68760, Physician/Medical as the l IF FEMALE: for use 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Year Month Day 4☐Pregnant at time of death 5 Other (specify) P.0. the a detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ pe 1 Yes 2 No 3 Probably 4 Unknown rappar Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 2□ No 1 Yes 1 Tes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 ursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 No 3 DOA 2 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred After 1 Accident 5 Pending 1 ☐ Yes 2 ☐ No To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A death. investigation 6 Could not be determined 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by 1 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of partier 11/15/04 D2346 D MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DAKWOOD Rd. Glen Burnie, MD 21061 Moheres 784S JUde DM 31. Date filed (Month, Day, Year) 32. Registrar's Signature State NOV 1 9 2004 Registrar

			For State Registrar	State of Ma	ryland / Depa <i>Cer</i>	artment of H			ene g. Ng.	
	Physici		Decedent's Name (First, Middle, Last) Randall Ky.	le Sha	aw			2. Date of Death Month October	200	3. 60 ft Death 5:30pm M
	/Medic Examin		4a. Facility Name (If not institution, give s Washington Adven		ital	4b. City, Town, or Tacoma I		h	4c. County of Dea	ytwo
	Funeral Director		220=70=8369	M 2□F	(In yrs. last birthday) 45 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.		9. Bir 957	thplace (State or Foreign puntry)
	Maryland -f show	tor	Usual Residence of Decedent 10a. State 10b. County VA Oray 9	SON	10c. City, Town or Lo	cation	Tries			10d. Inside City Limits 1 ☐ Yes No
	h with the 23a or 28a at be not	ai Director	10e. Street and Number 45 Sky Yark	LN.		10f. Zip Code	2433°) 10	g. Citizen of What Co USA	ountry?
900	hours after death with the Maryland tural', or Items 23a or 28a-f show al Exerciner must be nutified at	d by Funeral		12. Was Decedent E Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		Was Decedent of H f Yes, specify Cuba 1 ☐ Yes 2 No	ispanic Origin? (S In, Mexican, Puer Specify:	Specify Yes or No- to Rican, etc.)	14. Race - Am Black, Whi Specify: Wh	
Maryland 21215-0036	within 72 ene. than "nai	Completed	15. Decedent's Edui (Specify only highest grade Elementary/Secondary (0-12)		(Give	dent's Usual Occup, kind of work done of DO NOT use retired	during most of wo I)	rking 1	6b. Kind of Business	Nodustry
/land	buld be filed Mental Hygi arked other attc event, I	To Be C	17. Father's Name (First, Middle, Last) Elwood Shaw				18. Mother's Nat Dorot	me (First, Middle, M hy Morto:		
Baltimore, Mary	permit. Pages 1 and 2 should Department of Health and Men Important: If item 27 is marke any injury or other traumatic <u>once.</u>		19a. Informant's Name/Relationship (Ty, Dorotty Calot's C 20a. Method of Disposition 1 Burial 2 Cremation 3 R 4 Donation 5 Other (Specify) 21. Signature Fineral Service License	e Imothe	20b. Place of Dispo cemetery, cren Pleasant	sition (Name of natory or other place Grove Cer	ber Cre netery I	Date OZZIOY I	City or Town, State, , C\GYK Oc. Location - City or ndependence Home Inc.	Town, State ce VA.
	Physician /Medical Examiner	Examiner	23a. Part1. Enter the disease, of complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a	the death. Do not ent-		g, such as cardia	c or respiratory arre	ore MD 212	Approximate Interval Batween Onset and Death
P.O. Box 68760	that the death certificate be executed ed by the attending physician and detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	3c. If yes, outcome of 1 Live birth 2 4 Pregnant at the 9 Unknown	Petal death 3 ime of death 5	Ectopic pregnancy Other (specify)	en in Part I.	23e. Did toba	23d. Date of de Month	Day Year
Vital Records,	aw requires is been sign 2 should be	Completed by						1 ☐ Yes 24a. Was an autopsy perform	24b. Were as	obably 4 Unknown utopsy findings available completion of cause of
Vital F	sician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	lospital:		Oth	ar	1 Yes 2 ath (Check only one	No 1 Yes	2 No
Division of	ing After une	Certification; To	27. Manner of Death 1 Matural 5 Pending 2 Accident investigation	1 ☐ Inpatier 28a. Date of Injung (Month, Day	28b. Time of	28c. Injun	4 Nursing F	28d. Describe how		
DIV	Dir Dir		4 Homicide determined	building, etc.				City or Town,		
	To the Hospital within 24 hours a To the Funeral I completely filled	Medical	29a. Certifier Certifying Physical Constitution (Check only one) 2 Medical Examination (Check only one)	ner: On the basis of and manner stat	f my knowledge, death examination and/or inved.	vestigation, in my o	pinion, death occu	urred at the time, dat	te and place, and due	to the cause(s)
)	P ₹ P 8		1 huble	eeney/	7	Se	57619		1/19/04	,
_	5		30. Name and address of person who co Don N. Coleman MD	7600 Car:	roll Ave.		ark MD 20	0912		
	Sta Regist		31. Date filed (Month, Day, Year) NOV 1 9 2004	32. Registra		books				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend item 10h Waryland 8837 11-19-04 exith and Mental Hygiene 1 - For State Registrar Reg. No. 2 U D 4 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 0600 M **Physician** SUBEL PHILIP 200 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HUSPITAL BALTIMORE BAYVIEW Social Security Number N/A If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1**X**M 2□ F Months Days Hours 218-40-1862 6 Director 08/20/1943 MD Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28e-f show traumatic event, the Madical Examiner must be notified at 1 X Yes 2 □ No Director MD N/A YLTIMORE 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 1224 731 500 TH NZERNE F or items 23a USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after of Hygiene. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: WHITE Specify: 3 ☐ Widowed 4 ☑ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12 College (1-4or 5+) SALES RETAIL 12 should be filed wing and Mental Hygien Is marked other th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be SOBEL BEATRICE TABACHNICK ပ HYMAN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 st Department of Health and Important: if Item 27 is m any injury or other traum SHERRIE SOBEL / EX-WIFE 401 N.E. 14TH AVE. #706 - HALLANDALE, FL 33009 20b. Place of Disposition (Name of cemetery, crematory or other place) SEDEK 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State SHOMREI HADATH VE TZEMECH 11/18/04 * 4 ☐ Donation 5 ☐ Other (Specify) ROSEDALE, MD 21. Signature of Funeral Service License 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ARRHYTHMIA /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IDEMIA Examine burial-transit that the death certificate be executed PERFORATED Due to (or as a consequence of): Records, P.O. Box 68760 attending physician lcian/Medlcal the IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ó in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) the Physl 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an was a... autopsy performed? Yes 2 No 2 No 1□ Yes 1 Tyes Division of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 2 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After or Attending 1 Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident Diractor: 6 Could not be 3 🖺 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide after To the Hospital within 24 hours a To the Funerai [Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and marrier stated. icai 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) KES 000 30. Name and address of erson who completed cause of death (Item 23a) (Type, Print) +940 E A ENUE, Balto., D
REALTAMIN MANDEL, MD KAYNEW TIOSPITAL 212 KAYVIEW BENSAMIN MANDEL, 31. Date filed (Month, Day, Year) 32. Registrar's Signature State NOV 1 9 2004 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. U 0 4 Certificate of Death 2. Date of Death . Decedent's Name (First, Middle, Last) Month **Physician** Joseph O. Tosadori Nov. 14, 2004 11:22cm /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Upper Chesapeake Medical Center Belair, MD Harford If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Months **1** M 2 □ F Hours 176-12-8921 83 Director July 6,1921 PA Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show other traumatic event, the Medical Examination notified at MD 1 XYes 2 □ No Harford Forest Hill Director the 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ö 905 Delray Dr. 21050 USA or Items 23a Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. typyYes 2 ☐ No If Yes, Give 1 Never Married 25 Married 1 ☐ Yes 2 X No Specify: Specify: White à 3 Widowed 4 Divorced natural Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene Important: If item 27 is marked other than "I any injury or other traumatic event, the Mexany injury or other traumatic event, the Mexan Elementary/Secondary (0-12) College (1-4or 5+) Freezer operator Food 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Sante Tosadori Palma De Leoni 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Victoria Tosadori / Wife 905 Delray Drive, Forest Hill Maryland 21050 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3XXRemoval from State Christ Our Redeemer Cemetery 11/20/04 Pittsburgh, 1 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Victor P. Doda, Jr. 22. Name and Address of Facility Charles L. Stevens Funeral Home, Inc. 1501 East Fort Avenue, Baltimore Maryland 21230 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Due to (or as a consequence of): /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Listass or ir jury that initiated events resulting in death) Last Due to (or as a consequence of): burial-transit Due to (or as a consequence of): attending physician for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Dav Year 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the a detached f P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Pneumonia Tosadori, Joseph Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a To the Funeral I t 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

Registrar
DHMH 17 Rev 1/2001

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Mark Wild, 31. Date filed (Month, Day, Year) 2 North A 32. Registrar's Signature 355 22

Avenue Ste. 101, Bel Air, MD

November 15, 2004

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Catherine Tomaszewski 2004 l le /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BELANK NAKINER HEALTH W | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Worths | Days | Hours | Min. | Mar. | 20, 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** ^{Yea}(1908 1 M 2 F Pennsylvania 96 177-26-7857 **Director** Usual Residence of Decedent the Maryland show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-1 show other traumatic event, the Medical Evantical must be morthly at Director 1 ☐ Yes 2€ No Bel Air Md. Harford 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? filed within 72 hours after death with 21014 U.S.A. 300 Sunflower Drive, Apt. 373 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. ☐ Yes 2 🛣 No Yes, Give 1 Never Married 2 Married Specify: white Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Be Completed by 3 ➡Widowed 4 □ Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b, Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) homemaker own home 8 years 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) and Mental F be Eleanor Pospieszynska Dominic Sienkiewicz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1700 Cass Drive, Bel Air, Md. 21015 Frederic Tomaszewski/son Health tem 27 I If item 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Pages 1 1 Burial 2 Cremation 3 Removal from State permit. Page: Department of Important: If i ò 11/23/2004 St. Dominic Cem. Phila., PA * 4 □ Donation 5 □ Other (Specify) injury 21. Signature of Funeral Service Licensee Schimunek Funeral Home of Bel Air, Inc. Stefanie Lineke 610 W. MacPhail Road, Bel Air, Md. 21014 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** month disease or condition resulting in death) everal /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of): physician Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No 23d. Date of delivery 3 Ectopic pregnancy ò Month Dav Year 4 Pregnant at time of death 5 Other (specify) ed by the a detached f o. 9 Unknown 9 Unknown ئە signed t d be det Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy page performed certificate 2 ANO 1 ☐ Yes 2 ☐ No Vital Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death Check onl one examiner? Other: 2 1 Tes 2 THE 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ursing Home 5 Residence 6 Other (Specify) ē this After thi funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Medical Certification: Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation within 24 hours after deat To the Funeral Director: 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 1 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who ath (Item 23a) (Type, Print) ann P 31. Date filed (Month, Day, Year) 32. Registrar's Signature Registrar 9 2004 NOV 1

		Ľ	For State Registrar	State of M	aryland / Dep <i>Ce</i>	partment of Hertificate of L			ene 2004	36741
	o.		1. Decedent's Name (First, Middle	e, Last)				2. Date of Death Month	Day Year	3. Time of Death
	Physici /Medic		Albert Guy	Thomas				Worehor	17, 200 T	10:30 AM
}	Examin		4a. Facility Name (If not institution	, give street and number,)	4b. City, Town, or	Location of Death	n	4c. County of Deat	th
			Union Memorial		- // /- /- /-	Baltimor		100000000000000000000000000000000000000		
	Funeral Director		5. Social Security Number	6. Sex 7. A	ge (In yrs. last birthda Yrs.	Months Days	If Under 24 Hrs. Hours Min.	(Month, Day, 1	rear) Co	hplace (State or Foreign buntry)
			235–09–9323 Usual Residence of Decedent		86 *rs.			8/27/19	18 Wes	t Virginia
	yland	Ì	10a. State 10b. County		10c. City, Town or	Location				10d. Inside City Limits
	a-f s	ctor	Maryland Baltin	more	Essex					1 □ Yes 2 No
	ith the	Oire	10e. Street and Number			10f. Zip Code		10	g. Citizen of What Co	ountry?
	ath w	rail	1542 Galena Roa			21221		U	. S. A.	
	ltems	Funeral Director	11. Marital Status	12. Was Decedent Armed Forces	?	 Was Decedent of Hi If Yes, specify Cuba 	ispanic Origin? (S ın, Mexican, Puert	pecify Yes or No- o Rican, etc.)	14. Race - Ame Black, Whit	
36	72 hours after death with the Maryland naturel', or Items 23a or 28a-f show incal Exiginet must be natified at		1 Never Married 2 Marr 3 Widowed 4 Divorced	ied 12∑Yes 2 ☐ If Yes, Give Year or Dates:	WWTT	1 ☐ Yes 2 XNo	Specify:		Specify:	
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2	or the	Con	9	3		nanic			Automobile	9
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Maryland 21215-0036	12 sh h and 7 is m treum		19a. Informant's Name/Relations	1 () / - /		iling Address (Street a			,	,
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Baltimore,	ages nt of t: If it		1 Burial 2 □ Cremation 4 □ Donation 5 □ Other (S	3 Removal from State	1	ematory`or other plac		11/19		
量	a tme orten injur	ŀ	21. Signature of Funeral Service		The state of the s	Memorial 22. Name and Addres			el Air, Ma	aryland
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	/Medical		resulting in death)	Due to (or as	s a consequence of):	His	1)			Lot and I
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Exami	ner	4a. Facility Name (If not institution			4	b. City, Town, o TOWSC		of Death		4c.	County of De	imore
Funeral		Stella Maris Ho 5. Social Security Number		e (In yrs. last birti		If Under 1 Year	If Under	24 Hrs.	8. Date of Bi	rth	9 F	Sirthplace (State or Fore
Director		233-42-1144 Usual Residence of Decedent	1□ M 2 X F	75	Yrs.	Months Days	Hours	Min.	June 3	, 19	29	WV.
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1 and Health em 27 ther t		Linda Wagner 20a. Method of Disposition	Daughter	20b. Place of		ngression (Name of	onal I	Drive	,Westm			. 21158 or Town, State
permit. Pages 1 and 2 Department of Health s Important: If item 27 is any injury or other tra once.		1 ☐ Burial 2√ Cremation `4 ☐ Donation 5 ☐ Other (S	pecify)	cemeter	y, cremat v Cre	tory or other place ematory		Novem	2004	Bal	timore	City, MD.
Depar Impor any in		21. Signature of Funeral Service	Licensee	0	Cor	ame and Addre	ss of Facili unera	al Ho	me Of	Dund	alk,P.	Α.
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Physicia	an	1. Decedent's Name (First, Middle, La Well	S			Month	Pay	Year 7
/Medic Examin	er	4a. Facility Name (If not institution, give Security Number 6. S	fidal	e (In yrs. last birthda	4b. City, Town, or Location of E Be Hace MS	21223	Ba	CAL COLO C
Funeral Director			M 2]X] F	79 Yrs.		Hrs. 8. Date of Bir Vin. (Month, Da JUN 26	, 1925	9. Birthplace (State or Country)UnK
show		10a. State 10b. County		10c. City, Town or	Location			10d. Inside City
r 28a-1 s	Director	MD NA 10e. Street and Number		BAI	TIMORE 10f. Zip Code		10g. Citizen of	What Country?
23a o		1000 N. GIL	OR STREE		21217			ISA
al', or items 23a or 28a-f show Exeminer must be notified at	by Funeral	11. Marital Status 1 XNever Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 Yes 2 X If Yes, Give Year or Dates:	Ever in U.S. 13	 Was Decedent of Hispanic Origin If Yes, specify Cuban, Mexican, F Yes 2 No Specify: 	? (Specify Yes or Ne Puerto Rican, etc.)	Bla Speci	ice - American Indian, ack, White, etc. ify: AFRICAN AMERICAN
Hygiene. uther than "natural", or items 23a or 28a-1 show ant, tre Madical Examination must be notified at	Completed t	15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12)	ducation	(Gir	sedent's Usual Occupation ve kind of work done during most o DO NOT use retired) unk		Business/Industry unk	
Department of yealth and Mental Hygiene. Important: If item 27 is marked other than "naturany injury or other traumatic avant, it e Madical once.	Be	unk 17. Father's Name (First, Middle, Last	Name (First, Middle	e, Maiden Suma	me) unk			
and Mental is marked o	To	19a. înformant's Name/Relationship	(Type, Print)	19b. Ma	illing Address (Street and Number of	or Rural Route Numb	ber, City or Town	n, State, Zip Code)
m 27	11 9	ALBERT P. WYLIE		20h Blace of Die	638 N. GILMOR S	STREET BA	-	MD 21217 - City or Town, State
T ita		20a. Method of Disposition 1X Burial 2 Cremation 3 [cemetery, c	rematory or other place)			
tant:		*4 □ Doration 5 □ Other (Speci	/	MT. ZIO	ON CEMETERY 7, Name and Address of Facility	/1/04		WNE DA
Departn Imports any inju		21. Signature of uneral Service	nsee		638 N. GILMOR	WYLIE FUN	NEKAL HO BALTIMOR	
		23a. Part1. Enter the disease, or con	nplications that cause	d the death. Do not a	enter the mode of dving, such as ca			
0.77		shock, or heart failure. List only	one cause on each li	no Maria - trans		rulac of respiratory	airest,	Approximate
A R R R R R R R R R R R R R R R R R R R		Immediate Cause (Final	43.03	The second second	tic gastric canc	er	arrest,	Interval Betwo
nysician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. Lespi	ratory 1	tic gastric canc	er	arrest,	Interval Between
/Medical xaminer		disease or condition resulting in death)	a. Lespi	The second second	tic gastric cano	er	A Cotton	Interval Between
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	1 - For State Registrar 1. Decedent's Name (First, Middle	. Last)		eniiicate	of Death		Reg.	2004	36741 3. Time of Death
Physician /Medical		Eric Allen Wi	lliams			Nov	ember	13 2 ^{Year}	10:55 P.M
Examiner Funeral Director	4a. Facility Name (If not institution 4042 McDowell 5. Social Security Number 214 41 5403	Lane 6. Sex 7. Age	(In yrs. last birthda	lf Under 1	Baltimor Year If Under Days Hours	e 24 Hrs 9 Date	of Birth oth, Day, Ye.	Baltimo Baltimo 9. Birt Co 1993	
A =	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or	Location					10d. Inside City Limits
any injury or other traumatic event, the Modical Examiner must be notified at once. To Be Completed by Funeral Director	Maryland Bal	timore	Baltin	nore					1 ☐ Yes 2 🙀 No
niner must be notified Funeral Director	10e. Street and Number			10f. Zip (10g.	Citizen of What Co	ountry?
eral	4042 McDowe11	Lane 12. Was Decedent Ev	ver in U.S. 1		21227	igin? (Specify Yes	or No-	encan Indian,	
by Fun	1 XNever Married 2 Marri 3 Widowed 4 Divorced	Armed Forces?		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 □ Yes 2 ☒ No Specify: Specify: WY					
Completed	15. Decedent (Specify only highes Elementary/Secondary (0-12)	's Education t grade completed) College (1-4or 5+	(Gi	cedent's Usual ve kind of work DO NOT use tudent	Occupation done during mos retired)	st of working		. Kind of Business/	Industry
ပိ	5th 17. Father's Name (First, Middle, I	Last)		Ludello	18. Mothe	er's Name (First, I			<u> </u>
To Be	David	E. Williams			Nicole M. Hall				
	19a. Informant's Name/Relations David William		ty or Town, State, 2						
	20a. Method of Disposition	is / ractier	20b. Place of Dis	position (Name	ell Lane	Date		Maryland Location - City or	
	1 Daurial 2 Cremation '4 Donation 5 Other (S)		St. Joh	rematory or oth n's Cen		11/17/20	04 E1	licott C	ity, MD.
Souce	21. Signature of Funeral Service	Znamua	who		Address of Facili			al Servio	ce, P.A. ryland 2122
	23a. Paril. Enter the disease, of shock, or heart failure. List	mplications that caused the control one cause on each line	he death. Do not e	enter the mode	of dying, such as	cardiac or respira	tory arrest,		Approximate Interval Between
ın	Immediate Cause (Final disease or condition resulting in death)	-a Pontir	re Glion	ma					Onset and Death
al er	resulting in death)	Due to (or as a	consequence of):						1.
<u></u>	THE RESERVE LANCE	b. Due to (or as a consequence of):							11 months
mine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that introduced to the context of	Due to (or as a	consequence of):						11 months
cal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	С.	consequence of):						11 months
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			For State	State	of Maryland		artment rtificate			Menta		e .200	1 3671.E
			Registrar 1. Decedent's Name (First, Midd	le, Last)		001	invait	, OI L	Juli		e of Death		3. Time of Death
	Physicia		Margaret Wat	kins						Nov	ember	13 20	
	/Medic Examin		4a. Facility Name (If not institution		umber)				Location of Deat	th		c. County of De	
		7	4 Boxwood Rd		T- " "		Anna If Under		1 S If Under 24 Hrs	B Dat	e of Birth	Anne A	
	Funeral Director		5. Social Security Number 218-28-3732	6. Sex 1 ☐ M 2X F	7. Age (In yrs. I.	Yrs.	Months	Days	Hours Min.	Apr	nth, Day, Yea	1935 N	irthplace (State or Foreign Country) 1ary1and
	and w		Usual Residence of Decedent 10a. State 10b. Count	1	10c. City	, Town or Lo	ocation						10d. Inside City Limits
	Maryl f eho	ō	Maryland Anne	Arundo	1 An	napol	i a						1X Yes 2 □ No
	r 286	Director	10e. Street and Number	ALUMAE.		παίουτ	10f. Zip	Code			10g. C	itizen of What	Country?
	th with		4 Boxwood F	Load				2140	0.3				JSA
	ems ems	iner	11. Marital Status	12. Was De Armed F		S. 13.	Was Deced	lent of His offy Cubar	spanic Origin? (S n, Mexican, Puer	Specify Ye rto Rican,	etc.)	14. Race - Ar Black, Wi	nencan Indian, nite, etc.
36	should be filed within 72 hours after death with the Maryland Mental Hygene. marked other then "neturel", or litems 23a or 28e-f ehow matic event, the Mourel Exerciter most be notified a	Completed by Funeral	1 ☐ Never Married 2 ☐ Ma 3 ☐ Widowed 4 ☐ Divorce	If Yes C			1 ☐ Yes 2	2 X No	Specify:			Specify:	Black
Ö	turel	edb	15. Decede	nt's Education		16a. Dece	dent's Usua	I Occupa	tion		16b.	Kind of Busines	ss/Industry
215	nin 72	plet	(Specify only high Elementary/Secondary (0-12)	est grade completed College	(1-4or 5+)	life.	DO NOT us	n aone a se retired)	uring most of wo	onking			
212	giene giene er the	E	11th	0		Co	ok			V.,		estaura	int
nd	be file tal Hy d oth	Be	17. Father's Name (First, Middle						18. Mother's Na			en Sumame)	
yla		ပ	Thomas			10b Mailie	no Addross	(Stroot 3	Mary nd Number or R	r.	owner Cit	or Town State	Zio Code)
Mar	12 s h ar 7 le trau	1	19a. Informant's Name/Relation		l-		•		treet A				1
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should Department of Health and Men Importent: If item 27 le marke eny injury or other traumatic QDGB.		Veronica Well 20a. Method of Disposition	.IS (Dau	20b. P	lace of Dispo emetery, crei	osition /Nan	ne of		Date		Location - City	
nor	ages ant of it: If it		1 ⊠Burial 2 ☐ Cremation 1 ☐ Donation 5 ☐ Other							11/	18/04	Owens	ville, Md.
alti.	permit. Pa Departmen Importent: eny injury		21. Signature of Funeral Service	e Licensee			2. Name an						
ä	Dep Impo	1	23a. Part1. Enter We disease.	Beene MO	8483	1	mi i	eest	St. Sot	ns M	Ortuar Olis,	Ма 21	401
			23a. Part1. Enter we disease, shock, or heart failure. Li										Approximate Interval Between Onset and Death
E	Physician		Immediate Cause (Final disease or condition	, (or do o (or as a conseq NO C	ic F	145	ST					Oliser and Death
1	/Medical Examiner		resulting in death)	Due	o (or as a conseq	uence of):	,		Cara	til	10		
	Lxammer	-	Sequentially list conditions,	b	WOC	uence of):	al.	(V	Fuic	IV.	/		-
	ted	Examine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	≺	V	,							
,	be executed sician and burial-transit	Exal	that initiated events resulting in death) Last	c. Due t	to (or as a conseq	uence of):							
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9		Aed	IC CEMALE.										
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	e dea the at ned fo	Physiclan/Med	1 Yes 2 No	4 □ Pre 9 □ Uni	egnant at time of d known	leath 5	Other (sp	pecify)					
P.0	The law requires that the death certifica ate has been signed by the attending ph page 2 should be detached for use as it		Part II. Otas significant cond	tions cont. buting to	death but not res	ulting in	nderlying :	se give	en in Part I.	2:	3e. Did tobacc	o use contribute	to the cause of death?
ds,	urres t signe Id be	d by	Suster	While	bus h	WE	MI	S	is		1 🗌 Yes	2 NHO 3 []	Probably 4 Unknown
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Rec	The law cate has page 2 s	m d	- PONON	-100000		/					autopsy performed′ □ Yes 2501	7 I death	?
a			25. Was case referred to medi	cal					26. Place of De			, , ,	03 22.10
of Vital Record	Physicien: this certificated ral director, i	To Be	examiner?	Hospital:	☐ Inpatient 2 ☐	ER/Outpatie	ent 3 DC	Oth	er: 4 🗆 Nursing	Home 5	Residence	6 Other (S	(pecify)
	ding Phys n. After this funeral dir		27. Manner of Death 1 Natural 5 ☐ Pen	/8.4	ite of Injury lonth, Day Year)	28b. Time o Injury	of 2	28c. Injun Worl		28d. D	escribe how in	jury occurred	
9	andir sath. or: Al	Satio	2 ☐ Accident inve	stigation		<u> </u>	М		Yes 2 □No	006.1	tion (Ctront	and Nicobara	Description of Alexandra
Division	or Att	Certification:		minod 289. Pie	ace of Injury - At hilding, etc. (Special	ome, farm, st fy)	treet, factor	y, office			ity or Town, St		Rural Route Number,
	pital		29a, Certifier 12 Cartif	ying Physician: To	the best of my kno	owledge, dea	th occurred	at the tin	ne, date and place	ce, and du	e to the cause	(s) and manner	as stated.
	To the Hospital or Attanding Physicien: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	Medical	(Check only Medic	al Examinar: On the	e basis of examina nanner stated.	ation and/or in	nvestigation	n, in my o	pinion, death occ	curred at t	he time, date a	and place, and o	due to the cause(s)
	To the	Me	29b. Signature and vite of cert	fier	1		29	c. Licens	e number		29d.	Date signed (M	onth, Day, Year)
	×		1	uld	noc_		1	10 E	3198			117/0	7
	10		30. Name and address of pers	on who completed c	-	m 23a) (Type	e, Print)	Zo	5 Rido		Avel	, 4	
	•		JACKLI	CHENS		M	0	Ann	m Poli	5	MD	2140	/
	Regis	ate	31. Date filed (Month, Day, Ye NOV 1	9 2004	2. Registrar's Sign	A A	de	oak	2				

Amend item# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 7, perFH G837, 11/18/04 TT State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** Walker 6:22 AN NOV 2004 01 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner GOOD SAMARITAN Battimore MD N/A If Under 1 Year | If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 M 2 F Months Days Hours 245 503943 97 Yrs. Director 3 - 23 - 1907NORTH CAROLINA Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits item 27 Is marked other than "neturel", or Items 23a or 28e-f show other treumstic event, the Madical Examiner must be notified at 1 ☑ Yes 2 ☐ No Director NC ORANGE EFLAND 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 131 REDGATE RD. 27302 USA Be Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give A Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: BLACK 3 ₩idowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) HOUSEKEEPING DOMESTIC 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) and Mental I MABE WADE ALICE FULLER P 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health as Important: If item 27 Is any injury or other treu once. 1153 SHERWOOD AVE. BALTIMORE, MARYLAND 21239 WILFORD WALKER(SON) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Dispositief 20c. Location - City or Town, State 11-17-2004 1√2 Burial 2 □ Cremation 3 □ Removal from State
4 □ Donation 5 □ Other (Specify) BURLINGTON, NC JEFFERIES CROSS CEMETERY meral Service Lipensee JONATHAN D. HIBNER Name and Address of Facility DAVID B. LAWSON MORTUARY INC 21. Signature o 115 E. HARDEN ST. GRAHAM, NC 27253 Fiter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, repart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Preumm 10 days Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner 10 oresuble por rature (by history de Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Completed by Physiclan/Medical use as the 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 4☐Pregnant at time of death 5 Other (specify) been signed by the s should be detached t 1 ☐ Yes 2 ☐ No 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? arterios cleus 13 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Munknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ∠Yes 2 □ No page 2 autopsy performed? 2□ No wox over les 1∭X Yes 2 No Attending Physician: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) ို 28a. Date of Injury (Month, Day Year) completely filled in by the funeral 28b. Time of 28c. Injury at Work? 27 Manner of Death 28d. Describe how injury occurred Certification: After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A 2 Accident 6 Could not be determined 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 11/14/04 Hospital, Baltimore 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) an _ SAMARITAN 6000 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registra

			For Stete Registrer	State of Maryla				Mental Hygi) I.	26717
			Registrer 1. Decedent's Name (First, Middle, La	otl	<i>C</i> 6	ertificate of	Death	2. Date of Death	3	14	3 5 4 3. Time of Death
ı	Physici			si/ /urche				Month	Day	Year 2004	5:55 PM
	/Medic Examin		4a. Facility Name (If not institution, giv			4b. City, Town,	or Location of Dea	th	4c. County		3,331
	Funeral Director		5. Social Security Number 6.08 047–14–5272	CUARE HOS Sex 7. Age (In yrs CM 2 F 83		Roso // If Under 1 Yea Months Day:	r If Under 24 Hrs		<i>BA1</i> 1920	9. Birthpl Count	ICRE lace (State or Foreign try) Jersey
	fand wo		Usual Residence of Decedent 10a. State 10b. County	10c. C	ity, Town or	Location		-		10	Od. Inside City Limits
	Mary Ff sh	tor	Maryland Baltimor	re E	ssex						1 ☐ Yes XX No
	ith the	Oirec	10e. Street and Number			10f. Zip Code		10	g. Citizen of V	Vhat Coun	try?
	s 23a	rail	2013 Tred Avon Ro			2122			U.S.A		
21215-0036	d within 72 hours after death with the Maryland Jone. Ir than "natural", or Items 23a or 28a-f show It is Modical Exacilizational be notified at	by Funeral Director	11. Marital Status 1 ☐ Never Married 2X Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in the Armed Forces? 1 X Yes 2 □ No If Yes, Give Year or Dates:	WII	. Was Decedent of If Yes, specify Cu 1 ☐ Yes 2 ☑ No		Specify Yes or No- nto Rican, etc.)		e - America ck, White, e	etc.
5-0	72 ho	Completed	15. Decedent's E (Specify only highest gra		(Gis	edent's Usual Occi re kind of work don	e during most of we		6b. Kind of Bu	usiness/Ind	Justry
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d 2	Hyger Hyger		17. Father's Name (First, Middle, Last)	Autc	MOTKET	18. Mother's Na	me (First, Middle, M			
lan.	D to to	То Ве	Kasimir Yurche				Domicel	.a			unk.
Maryland	ges 1 and 2 should it of Health and Men I fitam 27 Is marke or other traumatic		19a. Informant's Name/Relationship (Туре, Print)				iurai Route Number,			· ·
	s 1 and of Health itam 27 other to		Don Yurche (Son) 20a. Method of Disposition	20b.		Berkfie.	ld Road,	Baltimore	, Mary		
nor	ages int of h t: If its y or of		1X Burial 2 □ Cremation 3 □ '4 □ Donation 5 □ Other (Special	Removal from State	cemetery, ci	ematory or other pi	- 1	20,2004 B		•	
Baltimore,	permit. Pages Department of H Important: If its any injury or of		21 Signature of the rai Se North								
m	Depare Important any ir					1407 Old	ruzazınsk 1 Eastern	Avenue,	HOMe, Essex,	P.A. Mary	land 21221
	Physician /Medical Examiner		23a. Parts sheet the disease, or come shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a. Sepsis	quence of):	nter the mode of dy	ring, such as cardia	c or respiratory arre	st,		Approximate Interval Between Onset and Death
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68760	icate be ex physician s the buria	edicai E	(_ d.					p.		
.O. Box	that the death certificate be executed ed by the attending physician and detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregr 1 ☐ Live birth 2 ☐ Fer 4 ☐ Pregnant at time of 9 ☐ Unknown	tal death 3	☐Ectopic pregnan ☐ Other (specify)	су		23d. Dat Mo	te of deliver	ry Day Year
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Re	e h	Com						autopsy perform	ed?	death?	npletion of cause of 2 No
Vital	ician: T certificat rector, pa	Be C	25. Was case referred to medical examiner?					ath (Check only one			
of V	SE	P	1 ☐ Yes 2 No		ER/Outpati	BIT 3 DOA		Home 5 Resider)
	ling After Tune	tion:	27. Manner of Death Natural 5 Pending Investigatio	28a. Date of Injury (Month, Day Year)	28b. Time Injury	W	uryat ork? ☐Yes 2☐No	28d. Describe how	w injury occurr	ed	
Division	at at	Certification:	2 Accident investigatio 3 ☐ Suicide 6 ☐ Could not be determined	De Can Place of John At	home, farm, sify)			28f. Location (Str. City or Town,		er or Rural	Route Number,
	To the Hospital or Atta within 24 hours after de To the Funeral Directo completely filled in by th	edical C	29a. Certifier 1 Certifying Pl (Check only one) 2 Medical Exer	hysician: To the best of my kr miner: On the basis of examin and manner stated.	nowledge, de nation and/or	ath occurred at the investigation, in my	time, date and plac opinion, death occ	e, and due to the cal urred at the time, da	use(s) and ma te and place, a	nner as sta and due to	ated. the cause(s)
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)	. (> AIMUT	aira		RE	5 0000	7	11//	7/	04
	741		30. Name and address of person who DR EID AlmuT	completed cause of death (Ite	am 23a) (Typ	Print)	ARE DR	. BAITi	MORE	Md	21237
	Sta		31. Date filed (Month, Day, Year) NOV 1 9 2004	32. Registrar's Sign	nature	lon V.					

DHMH 17 Rev 1/2001

FRANK YURChe

		1	For State Registrar	State of M	laryland /	•	artment of H		and Mental I	Hygier Reg. 1	20114	36748
			1. Decedent's Name (First, Middle, La						2. Date of Month	Death	Day Year	3. Time of Death
	Physici /Medic	ai -	Audrey B. Akerma						Noven	ber	5, 2004	10:10 p.M
	Examin	er	4a. Facility Name (If not institution, gi		7)		4b. City, Town, or Freder		of Death		4c. County of Dear	_
	Funeral		8421 Aynsley Cot 5. Social Security Number 6.		ge (In yrs. last	birthday)	If Under 1 Year	If Under		Birth		thplace (State or Foreign
	Director		139-32-4774	1□M 2 只 F	65	Yrs.	Months Days	Hours	Augus t	24,	1939 Pe	nnsylvania
	and and		Usual Residence of Decedent 10a. State 10b. County		10c. City, T	own or Lo	cation					10d. Inside City Limits
	Mary 9-f eh	ţoţ	Maryland Frederi	i ck	Fre	deri	ck					X∏Yes 2∏No
	172 hours after death with the Maryland "natural", or items 23e or 28e-f ehow rdical Examiner must be notified at	ai Director	10e. Street and Number 8421 Aynsley Cou	ırt		-	10f. Zip Code 21702		**	10g.	Citizen of What Co	ountry?
	r deat	Funeral	11. Marital Status	12. Was Deceden Armed Forces	?	13. \	Was Decedent of Hi f Yes, specify Cuba	ispanic Ori	gin? (Specify Yes or , Puerto Rican, etc.	No-	14. Race - Ame Black, Whit	
36	rs afte f, or i	by Fu	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 € If Yes, Give Year or Dates			1□Yes 2€ No	Specify:			Specify:	white
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/lan	2 should be f and Mental h is marked of raumetic eve	To B	Charles C. Bail	Ley				Mar	y Love			
	12 = Z		19a. Informant's Name/Relationship Greg Akerman -	(Type, Print) SON					Frederic			Zip Code) 21702
altimore,	Pages 1 ar ent of Hea nt: If item ry or othe		20a. Method of Disposition 1 StBurial 2 Cremation 3 4 Donetion 5 Other (Spec		ceme	etery, crer	sition (Name of natory or other plac Memoria 1		Date 1/9/2004	1	Location - City or ederick,	Town, State Maryland
Balti	permit. Pages 1 Department of h Important: If ite any injury or ot		21. Signature of Funeral Service Le		Eline		. Name and Addres		. Stantie			mes, P. A. ryland21702
			23a. Part1. Enter the disease, or conshock, or heart failure. List only	mplications that cause y one cause on each	ed the death. (Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	a. 🗸	7 N 01	/ /	Failu-	2				Onset and Death
F	/Medical Examiner		resulting in death)	Due to (or a	is a consequen	nce of):						Ch-0916
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or a	is a consequen	nce of):		/ / /	ector			(2) 6 // (
	acuted ind transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last		-51 451		nn1 (- = /	1 (1-	- < 1	70-77	
8760,	be executed sician and burial-transit		resulting in death) Last	Due to (or a	is a consequen		151	d.	2 = 4 5			8 4-7
687	ficate physics the last the la	edical		d	, , , ,							- J
Вох	death certifica attending pl	M/ue	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom	ne of pregnancy 2 Petal de		Ectopic pregnancy				23d. Date of de	
Ö	that the deal	Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		at time of death		Other (specify)				Month	Day Year
Q.	es that igned by be deta	by Pr	Part II. Other significent conditions	-	but not resulting	ng in the u	nderlying cause give	en in Part I	. 23e. C	id tobacc	o use contribute to	the cause of death?
ord	w require been sig should b	ted	metost.	7513	60		107-			Yes	2 No 3 Pr	obably 4 Unknown
of Vital Records,	has has	Completed							a	Vas an utopsy erformed s 220	prior to death?	utopsy findings available completion of cause of
ital	ysician: Th is certificate director, pag	BeC	25. Was case referred to medical examiner?						of Death (Check or		10 10	23,10
of V	d is	2	1 Yes 2 No 27. Manner of Death	Hospital:		VOutpatien		4 🗀 140	rsing Home 5 F		6 ☐Other (Spe	cify)
		tion	1 Datural 5 Pending 2 Accident investigati	28a. Date of In (Month, E	Day Year)	Injury	Wor	k? Yes 2□		De How II	ilary occurred	
Division	l or Attending Ph after death. Director: After th in by the funeral	Certification:	3 Suicide 6 Could not determine	4 286. Place of I	njury - At home etc. (Specify)	e, farm, str	eet, factory, office			on (Street Town, St		ural Route Number,
_	To the Hospitel or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Medical C		Physicien: To the besominer: On the basis and manner:	of examination							
	To the Within To the	Me	29b. Signature and title of certifier		/		29c. License				Date signed (Mont	
)	X		1		147	•	DI	46 3	C	14	100 -6	,500%
	10		30. Name and address of person wh				Print)	· c	Fred.	/	a mb	21701
	Str	ate	31. Date filed (Month, Day, Year)		trar's Signature	ө	, , ,		/	160		
	Regist		NOV 0 S	2004	<u> </u>							

Disc. 1		Decedent's Name (First, Middle	111/5/04, HW, MX	· -					Date of Dea Month		004	V. Tole of Death.
Physici /Medic		Paul Edward							Novembe	$r^{\mathcal{A}_{\bullet}^{a^{y}}}$	2004 ^{ar}	12:20 A.
Examin	er	4a. Facility Name (If not institution Montgomery Gene				Town, or lney	Location of	of Death			ounty of Death	
Funeral		5. Social Security Number		e (In yrs. last birthday) If Under	1 Year	If Under	24 Hrs.	8. Date of Birth		_	nplace (State or Forei
Director		216-12-4886 Usual Residence of Decedent	1 ∑ M 2□F	83 Yrs.	Months	Days	Hours	Min.	8. Date of Birth (Month, Day January 2	2 , 192	Mar	yland
e Marylar Ba-f show	ctor	Maryland Montgo	omery	10c. City, Town or t Rockvill	ocation E							10d. Inside City Limi 1 XYes 2 □ N
th with tr 23a or 2 ant be no	al Dire	10e. Street and Number 4401 Chestnut 1	Lane		10f. Zip 20	0853				_	of What Cou	•
permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If tiem 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic evant, the Modical Examiner must be notified at once.	by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☑ Marr 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces? ied 1 Yes 2 1 If Yes, Give Wear or Dates.		Was Deced If Yes, spec	offy Cuba	n, Mexican	gin? (Spe i, Puerto f	cify Yes or No- Rican, etc.)		Race - Amer Black, White pecify:	
ithin 72 no ne. han "natur e Medical I	Completed	15. Deceden (Specify only highes Elementary/Secondary (0-12)	's Education it grade completed) College (1-4or 5	5+) (Give	edent's Usua a kind of wor DO NOT us	rk doné d se retired	during mos ()		ng		of Business/li	,
filed w Hygier other th		12 17. Father's Name (First, Middle,	Last)	Taxi/	Limos	ine			(First, Middle,		nsport	ation
nould be f Mental narked c	To Be	Adrian Frederic					Esth	er G	arber			
and 2 sr ealth and n 27 is n		19a. Informant's Name/Relations Irene W, Arkeba		4401	Chest	nut			Route Number		own, State, Zi 20853	ip Code)
Pages 1 nent of H int: if iter iry or pit		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 1 ☑ Donation 5 ☐ Other (S)		20b. Place of Disp cemetery, cre Geo. Wash Medical C	matory or o	ther plac	ity N	Vovem 200	ber 4		ion - City or T Ington	
permit. Departn imports any inju		Signature of Funeral Service	Cercl	2	2. Name an	d Addres	s of Facilit	ry S Wash	ervices ington,			
Physician /Medical		23a. Part1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)	only one cause on each life	the death. Do not en	iter the mod	e of dyin						Approximate Interval Between Onset and Death
cate be executed we have in the burial-transit and the burial-transi	ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	a consequence of:								
ath certif	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal death 3	⊒Ectopic pro					23d	. Date of deliv	very Day Year
uires that the de signed by the a id be detached f	by	Part II. Other significant condition Hyponatr		out not resulting in the t	underlying ca	ause give	en in Part I.		1			the cause of death?
The law requir cate has been s page 2 should	Completed	Urinary	Tract Infect	ion					24a. Was a autops perform	med?	prior to co death?	opsy findings availab
ding Physician: After this certifications of the director, in the directo	To Be	25. Was case referred to medical examiner? 1 Yes 22 No 27. Manner of Death 1-2 Natural 5 Pendin 2 Accident investig				Bc. Injury Work	r: 4□ Nu	rsing Hom	1 ☐ Yes 2 Check onl on ne 5 ☐ Reside 8d. Describe ho	ence 6	Other (Speci	2□ No
To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Certification;	3 Suicide 6 Could r 4 Homicide determ	ined 286. Place of inju	ury - At home, farm, st c. (Specify)	reet, factory	, office		2	8f. Location (St City or Town		umber or Run	al Route Number,
To the Hospita within 24 hours To the Funeral completely filled	Medical (29a. Certifier Certifyin (Check only 2 Medical one)	g Physicien: To the best examiner: On the basis of and manner sta	t examination and/or in	th occurred anvestigation,	at the tim in my op	e, date and pinion, deat	d place, a	nd due to the ca d at the time, d	ause(s) and ate and pla	d manner as s ce, and due t	stated. to the cause(s)
withir To th comp	Me	29b. Signature and title of certified Wilker		Ninal		License 4528					gned (Month,	-
	11.14	30. Name and address of person										

			1 - For State Registrar	State of Marylan		artment of H		Mental Hygi	ene 2004	36750
H	Physicia /Medic		1. Decedent's Name (First, Middle, Last) Jean Stuar	rt Ander	son			2. Date of Death Month November	Day Ye	
	Examin		4a. Facility Name (If not institution, give st 45415 Tippett 1	Road			11ywood		·	Mary's
	Funeral Director		5. Social Security Number 6. Sex 214-74-1063	7. Age (In yrs. 58	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min		Year)	Birthplace (State or Foreign Country) Scotland UK
	e Maryland 3a-f show	ctor	10a. State 10b. County Maryland St. Mar		y, Town <i>o</i> r Lo		lywood			10d. Inside City Limits 1 ☐ Yes 2 ■ No
	eth with the 23a or 24	rai Director	10e. Street and Number 45415 Tippett 1				636		og. Citizen of What United S	tates
020	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "neturel", or itema 23a or 28a-f show any injury or other traumatic event, the Medic. Examiner must be notified at once.	by Funerai	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	 Was Decedent Ever in U. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☑ No	lispanic Origin? (S an, Mexican, Puer Specify:	Specify Yes or No- to Rican, etc.)		merican Indian, Inite, etc. White
0-0171	within 72 h ene. than "netu ne Medical	Completed	15. Decedent's Educi (Specify only highest grade Elementary/Secondary (0-12)	ation completed) College (1-4or 5+)	16a. Dece (Give life.	dent's Usual Occup kind of work done o DO NOT use retired	during most of wo	orking 1	6b. Kind of Busine	
אומוות ע	ould be filed Mental Hygi arked other atic event, I	To Be Co	17. Father's Name (First, Middle, Last) Andrew Ross				18. Mother's Na	me (First, Middle, M	laiden Surname)	
, Mar	and 2 sho salth and n 27 Is m		19a. Informant's Name/Relationship (Typ Leon G. Anderson	/ Husband	45415	Tippett		ural Route Number,		
altillore	Pages 1 nent of Hi ant; If Iter ury or oth		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Re 1 ☐ Donation 5 ☐ Other (Specify)	moval from State	emetery, crer .nsfiel	osition (Name of matory or other place _d-Echols	11-	11-2004 C	oc.Location-City	Hall, MD
חשוב	permit. Departi Import. any inj		21. Signa Juneral Service Licesee Edward N. Brinsfie							Home, P.A. MD 20650-0279
	Physician /Medical Examiner usu-transit	Examiner	23a. Par1. Enter the disease, or complic shock, or heart failure. List only one immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	e cause on each line.	Ylmay uence of):	er the mode of dyin		,	st,	Approximate Interval Between Onset and Death
O. DOX 00/00,	The law requires that the death certificate be executed are has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Medical	d. IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 Mo 9 Unknown	lc. If yes, outcome of pregna 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of d 9 □ Unknown	Ideath 3	Ectopic pregnancy Other (specify)	,		23d. Date of Month	delivery Day Year
cords, r	equires that en signed b	by	Part II. Other significant conditions cont Breast Cauc		ulting in the u	nderlying cause giv	en in Part I.	23e. Did toba	.	e to the cause of death? Probably 4 □Unknown
ני		Completed						24a. Was an autopsy perform	prior	
VISION OF VITAL	To the Hospital or Attending Physiclen: The law within 24 hours elter death. To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2	ation; To Be	25. Was case referred to medical examiner? 1 Yes	ospital: 1 Inpatient 2 Inpatient 2 Saa. Date of Injury (Month, Day Year)	ER/Outpatier 28b. Time o Injury	f 28c. injur	er: 4 🗆 Nursing	ath (Check only one Home 5 X Resider 28d. Describe how	nce 6 Other (S	Specify)
DIVIS	To the Hospital or Attending within 24 hours effer death. To the Funerel Director: After completely filled in by the funer	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At he building, etc. (Specif	y)			City or Town,	State)	Rural Route Number,
	the Hosp hin 24 hou the Fune npietely fi	Medicai	29a. Certifier (Check only one) 2 Medical Examin 29b. Signature and title of certifier	ician: To the best of my kno er: On the basis of examina and manner stated.	wledge, deat tion and/or in	h occurred at the tin vestigation, in my o	pinion, death occ	urred at the time, da	te and place, and	due to the cause(s)
4	100 100 100 100 100 100 100 100 100 100		199	CLA	23a) (Tuna	H5	575		d. Date signed (Mi	
	Sta	ate	30. Name and 5 ess of person who cor Jennifer Schmi 31. Date filed (Month, Day Year)	dt, D.O., 234	15 Thi		Road, C	alifornia	, Maryla	nd 20619
	Regist	rar	MUV 7 2	2004 Magan	A Pho	Come				

			For State Registrar		State	of Marylar		artment of H		d Mental Hy	giene		36751
			Decedent's Name (First,	Middle, Las	(t)					2. Date of De. Month	ath		3. Time of Death
	Physicia /Medic		James		Duane	A	tkins			Novemb	er 3	2004	9:30 p ^M
	Examin		4a. Facility Name (If not ins	titution, give	street and nu	imber)		4b. City, Town, o	or Location of De	eath	4c.	County of Deat	h
			608 Clark Av			** A //	In an trinstal and	De If Under 1 Year	eale	ire Detect Bid		nne Ari	
	Funeral Director		5. Social Security Number	6. Se	ex STM 2□F	7. Age (In yrs. 66	Yrs.	Months Days		in. 8. Date of Bin (Month, Da Oct 28	y, Yeer) 1 Q	38 Was	hplace (State or Foreign untry) h., D.C.
			578-48-1834 Usual Residence of Decede	ent		00				CCL 20	, 10	JU Was	
	nylanc how		10a. State 10b. C	ounty		10c. Ci	ty, Town or Lo						10d. Inside City Limits
	Be-f s	Director		ne Aru	ndel				ale				1 ☐ Yes 2 No
	vith th	Die	10e. Street and Number					10f. Zip Code			10g. Citi:	zen of What Co	untry?
	72 hours after death with the Maryland natural; or Items 23a or 28e-f show deal Examber must be notified at	Funeral	608 Clark Av	renue_	12. Was Dec	edent Ever in U	J.S. 13.		751 Hispanic Origin?	(Specify Yes or No		USA 14. Race - Ame	ncan Indian,
0	r Item	Fun	1 Never Married 2	Married	Armed F 1 ☐ Yes	orces? 2 ⊠No				(Specify Yes or No lerto Rican, etc.)		Black, White	e, etc.
2	ral', o	by	3 ☐ Widowed 4 ☐ Div		If Yes, G Year or I	ive		1 □ Yes 2 🔀 No	Specify:			Specify: W	hite
315-003b	72 h 'natu	Completed		cedent's Ed highest gra	ducation de completed,	}	(Give	dent's Usual Occup kind of work done	during most of v	working	16b. Kii	nd of Business/	Industry
7	within ane. then	dw	Elementary/Secondary (0)-12)	College	(1-4or 5+)		<i>DO NOT use retire</i> al superv			LIC	Poctal	Service
N 0	e filed within 72 hours after death with the Marylan al Hygiene i other then "natural", or flems 23a or 28e-f show vent, the Mcdical Examble must be notified at	e Co	12 17. Father's Name (First, M	liddle, Last)			posta	it superv		Name (First, Middle,			service
and		To B	James Os	scar	Atk	ins			Marie	Fran	ces	McG	ahev
Mary	ages 1 and 2 should be nt of Health and Mental t: If item 27 Is marked t f or other traumatic ev	_	19a. Informant's Name/Rel				19b. Maili	ng Address (Street		Rural Route Number		Town, State, 2	Zip Code)
	and 2 Balth a n 27 ls		Carol T. Atk	ins,	wife				enue, D	eale, MD	207		
altımore,	of He of He if item		20a. Method of Disposition 1 Burial 2 □ Crem]Removal from	State	cemetery, cre	sition (Name of natory or other pla		Date		cation - City or	Town, State
Ē	Pages tment of tant: If it iury or o		`4 Donation 5 □ Ot	her (Specify	y)	Ft			and the same of th	-08–2004	Bre	entwood,	, MD
ga	permit. Page Department of Important: If any injury or once.		21. Signature of Fonenil S	arvica Licen) I			2. Name and Addre		-ma D 7	~	ringa N	MD 20736
			23a, Part1. Enter the disea	ase, or com	plications that	caused the dea				ome, P.A.		vings, i	Approximate
4			shock, or heart faiture tmmediate Cause (Final	a. List only	one cause on	each line.		reatic					Interval Between Onset and Death
	Pnysician /Medical		disease or condition resulting in death)	-	a	(or as a conse		700017	Colore	O.			yucos,
	Examiner					(3. 43 4 33.133	40000 0.,.						
		ner	Sequentially list conditions if any, leading to immediat cause. Enter Underlying	ė	Due to	(or as a conse	quence of):						
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60 ,	be executed sician and burial-transit		resoning in death, cast		Due to	(or as a conse	quence or):						
9789	ate hys	dical			_ d								
Box 6	eath certific attending p	Physician/Me	IF FEMALE: 23b. Was decedent pregna	ant		utcome of pregn					2	23d. Date of deli	ivery
m	death e atte	icial	in the past 12 months 1 ☐ Yes 2 ☐ No		4☐Preg	birth 2□Fet mant at time of		∃Ectopic pregnanc ∃Other <i>(specify)</i> _	ry .			Month	Day Year
O.	at the de by the a	hys	9 Unknown		9□ Unk	nown							
	s the	by	Part II. Other significant c	onditions c	contributing to	death but not re	sulting in the u	nderlying cause gr	ven in Part I.				othe cause of death?
ord	w require been sig should b	ted								-		% 3 □ Pr	obably 4 Donkhown
Records,	has b	Completed								- 24a. Was		24b. Were au prior to death?	topsy findings available completion of cause of
E F										1 ☐ Yes	2 X No		2 No
Vita	Attending Physicien: r death. ector: After this certifica	o Be	25. Was case referred to n examiner? 1 \(\text{Yes} 2 \text{Xo} \)	nedical	Hospital:	Inpatient 2	ER/Outpatie	nt 3 DOA	har	Death (Check only of Home 5 \(\sum{\chi}\) esi		S □Other /Sner	crhs)
ō	Phys ar this aral d	-	27. Manner of Death		28a. Date	of Injury	28b. Time o	f 28c. Inju	ry at	28d. Describe			sity)
<u>o</u>	ath. r: Afte e fun	atio		Pending investigation		nth, Day Year)	Injury		rk?]Yes 2 □No				
Division of	if or Attending Pafter death. Director: After to in by the funera	Certification;		Could not be determined		ce of tnjury - At I	nome, farm, st	reet, factory, office		28f. Location (. City or To			ıral Route Number,
	itel or A rs after ret Directed in by												
	To the Hospitel or At within 24 hours after or To the Funerel Direct completely filled in by	edical			miner: On the	basis of examin				ace, and due to the ccurred at the time,			
	To the within 2 To the complet	Med	29b. Signature and title of	certifies _	anuma	nner stated.		29c. Licen	se number		29d. Dat	e signed (Monti	h, Day, Year)
	F 3 F 8		1	Lei	HU	$\alpha_j \alpha$)	0	19838	×	1//	5/04	
•			30. Name and odress of	person who	completed car	use of death (Ite	em 23a) (Type,	Print)	(()	1	1	0:	
	15		Strart_	Selou	uch	1168	Ha	clear O	ah cri	we F	INM	igores	ucd.
		ate	31. Date filed (Month, Day	Year)	32. 5 2004	Registre's Sign	nature /	Print) Control	p				
	Regist	rar	[10 A Q	J 2004	MACHELA	10	19/1					

			Amend item#23a-b	,25,27, per State of N	ME, G83 Maryland	36K In / Depa	7177 (artmer	Prink r Ensurent of Health an	d Mental H	s Are ygiene	Legible.	0.0	mm pmm A
		_	For State Registrar			Cei	tifica	te of Death		Reg. No	2004	36	752
	nysicia Medic		 Decedent's Name (First, Middle, Thomas Sherma 	_					2. Date of D Month A J q ک	Da	y 9 200	. 1	3 14 PM
	xamin		4a. Facility Name (If not institution,	give street and number	er)	1	4b. City	Town, or Location of D	Death		County of Dea		
				Sex 7.	Age (In yrs. las		If Unde	amoriage		Birth	Horch 19.Bi	rthplace (Sta	te or Foreign
	neral ector		221-32-0854 Usual Residence of Decedent	1 X M 2□F	53	Yrs.	Months	Days Hours	April	Day, Year)		elawar	
yland ow	4		10a. State 10b. County		10c. City, T	Town or Lo	cation					10d. Inside	e City Limits
Mar.	Illoci	ctor	MD Dorch	nester				Vienna				101	es 2 No
5-0036/ 72 hours after death with the Maryland	or se no	Funeral Director	10e. Street and Number 4511 Ocean Gat	ceway			10f. Zi	Code 2186	59	10g. Cit	tizen of What C		
er deatl	Decou	uner	11. Marital Status 1 ☐ Never Married 2 ☐ Marrie	12. Was Deceder	s?	13.	Was Dece f Yes, spe	dent of Hispanic Origin city Cuban, Mexican, P	? (Specify Yes or Nuerto Rican, etc.)	10-	14. Race - Am Black, Wh		١,
21215-0036 od within 72 hours after gjene.	Exem	Completed by F	3 Widowed 4 Divorced	If Yes, Give Year or Date:	s:Vietna	m	1 🗆 Yes	•			Specify: W.		
_ ~ *	edica	lete	15. Decedent's (Specify only highest	Education grade completed)	1	(Give	kind of w	ial Occupation ork done during most of use retired)	working	16b. K	6b. Kind of Business/Industry		
vithin 4	N S	duc	Elementary/Secondary (0-12) 12	College (1-4d	or 5+)			erintenden:	t		constru	ction	
C Bigg	be fill d oth	BeC	17. Father's Name (First, Middle, La	ist)					Name (First, Midd	le, Maiden	Sumame)		
Maryland d 2 should be file th and Mental Hy	should be and Mental marked o umatic eve		Chester Verno	ı Bly			Virginia Semple						
and N	other traumatic	၉	19a. Informant's Name/Relationshi	o (Type, Print)	1	19b. Mailir	ng Addres	s (Street and Number o	r Rural Route Num	ber, City	or Town, State,	Zip Code)	
5 75 N	. 5		Amanda Bly	daughte	-			ist Mill Ro		-	_	19966	
ore of He	to de		20a Method of Disposition 1 ☐ Burial 2 🕱 Cremation 3	i ⊟Removal from Sta	ite cem	-	natory or	other place)	Date	20c. L	ocation - City o	r Town, State	•
Pages treent of	Jury		*4 □ Donation 5 □ Other (Spe	cify)	Sali			-	3/20/04		lisbur		
Baltimore, permit. Pages 1 and Department of Heeli moodant. If land	any in		21. Signature of fruneral Service 22. 23a. Part1. Enter the disease, or o shock, or heart failure. List or	m		, i	700 L	nd Address of Facility OCUST St.,	Cambridg	e, M			
Exam	dical	Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to ammediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or a Du	as a consequer as a consequer as a consequer	rce of):		oticardio	M. APPROVED B	-			nd Death
8760, ate be ex	the burl	ā		d				CENT CHIC	M APPRO			0000	
P.O. Box 687 nat the death certificate	deteched for use es the	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No		2 ☐ Fetal de t at time of deat	ath 3	Ectopic p	pregnancy			23d. Date of de Month		Year
Records, P.O The law requires that the	5 8	ğ	Part II. Other significant condition	s contributing to death	h but not resultii	ng in the u	nderlying	cause given in Part I.		tobacco i	use contribute t □ No 3 □ P		of death?
Records, The law requires t	nes been s je 2 should	Completed							24a. Wa	opsy	24b. Were a	utopsy findir	igs available of cause of
T a a	eßed	Con							per 1 ☐ Yes	formed? 2 <mark>/Q/</mark> No	death?	s 2□ No	
of Vital Physician:	director, pege	Be (25. Was case referred to medical examiner?	11	- A			77 - 2002 - 1004	Death (Check only	one)			
_ × º	andire	ို	1 Yes 2 No	Hospital:		VOutpatier			ng Home 5 ☐ Re			ecify)	
Vision C	r: Aller le funera	atlon;	27. Manner of Death 1 Natural 5 ☐ Pending 2 ☐ Accident investiga	tion	Day Year)	Bb. Time o Injury	м	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe	a now injui	ry occurred		
	d in by th	Certification;	3 Suicide 6 Could no 4 Homicide determin	ad 286. Flace 01	Injury - At home etc. (Specify)	e, farm, str	eet, factor	ry, office		(Street and own, State	nd Number or R e)	lural Route N	lumber,
To the Hospitel	etely fille	edical (s of examination			at the time, date and p n, in my opinion, death o					se(s)
To the	dwoc	Me	29b. Signature and title of certifier				29	c. License number		29d. Da	te signed (Mon	th, Day, Yea	r)
) []	,		• Michle	Taier	w, 1	NK	2/	060295		8	/23,	104	
			30. Name and address of person w Michelle Par		of death (Item 2:			439, Camb	ridge, MI	21	613	,	
E R	Sta Registr		31. Date filed (Month, Aux Year)		strar's Signatur	is a	bout	2					

State of Maryland / Department of Health and Mental Hygien 2004 For Stata Ragistrar 36753 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** November 2, 2004 5:00 Beach /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Montgomery Kensington Park Assisted Living Kensington 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Feb. 28, 1920 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** Months 1 ☐ M 2 🕱 F 579-12-4828 84 Yrs. Washington, Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Evantment must be notified at once. 1 Yes 2 No Director Maryland Kensington Montgomery 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20895 USA 3618 Littledale Road Completed by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give 1 Never Married 2 Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 Ho Specify: If Yes, Give Year or Dates: 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Hugh Stevens Smith Gena Bay Chapin 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 15500 Barnesville Road, Boyds, MD 20841 Jeffrey E. Beach/ Son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition November 23 1 Burial 2 Cremation 3 Removal from State Arlington National 4 □ Donation 5 □ Other (Specify) 2004 Arlington, Virginia Cĕmetery 21. Signature of Funeral Service Licens 22. Name and Address of Facility Prancis J. Collins Fu 500 University Blvd, Funeral Home Inc. MD 20901 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) a Cerebrovascular Accident /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Atherosclerotic Heart Disease Due to (or as a consequence or): Examiner and I-transit The law requires that the death certificate be executed H ertension Due to (or as a consequence of): sician ar e burial-t 68760 Physician/Medical attending physi Box IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) ed by the a P.O. 9 CUnknown been signed be should be deta 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records. þ Deep Venous Thrombosis, Dementia 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has b 1 ☐ Yes 2√ No Division of Vital or Attanding Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other 4 Nursing Home 5 Residence 6 Nother (Specify) Assisted Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 10 1 Yes 2 No this ä 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After Facility 1 XNatural Injury 5 Pending death. 1 ☐ Yes 2 ☐ No 2 Accident investigation within 24 hours after deat To the Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) à 4 Homicide To the Hospital 1 Carifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of D53691 November 3, 2004 YW 10 30. Name and address of person v ho completed cause of death (Item 23a) (Type, Print) Ajay P. Reddy, 6320 Democracy Blvd., M.D. Bethesda, MD 20817 31. Date filed (Month, Day, 32. Registrar's Signature State NOV 04 2004 Registrar

				partment of Health and Me ertificate of Death	ental Hygier	CUIII	36754
	Physici /Medic	al	Decedent's Name (First, Middle, Last) Mary Allen Boston 4a. Facility Name (If not institution, give street and number)		October 29	Day Year 9 2004 4c. County of Death	3. Time of Death 11:45 A ^M
	Examin Funeral Director	er	Sligo Creek Nursing Home 5. Social Security Number 6. Sex 1 - M 2 XIF 92 7. Age (In yrs. last birthday 110-01-7002	Takoma Park // If Under 24 Hrs.		Prince Geo	place (State or Foreign
	Maryland a-f show	tor	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or L MD Prince Georges Takoma	ocation			10d. Inside City Limits 1 √ Yes 2 □ No
	eath with the	by Funeral Director	10e. Street and Number 7525 Carroll Avenue 11. Marital Status 12. Was Decedent Ever in U.S. 13	10f. Zip Code 20912 Was Decedent of Hispanic Origin? (Spec	Uni	ited State	es
-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23s or 28s-f show other traumatic event, the Mudical Examinational be notified at	ed by Fun	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No If Yes, Give 3 ☐ Widowed 4 ☐ Divorced Year or Dates:	. Was Decedent of Hispanic Origin? (Speinf Yes, specify Cuban, Mexican, Puerto F 1 ☐ Yes 2 ☐ No Specify: edent's Usual Occupation		Black, White, Specify: Afri Amer	ican rican
121215-0036	led within 72 ygjene. her than "nai it, the Medic	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 11	e kind of work done during most of workin DO NOT use retired) Radio Technician	ng	Electroni	
Maryland	should be fil and Mental H s marked ott umatic even	To Be	17. Father's Name (First, Middle, Last) Ferdinand Allen 19a. Informant's Name/Relationship (Type, Print) 19b. Mai	Clara War			
45	ages 1 and 2 ant of Health at: If Item 27 is y or other tra		20a. Method of Disposition 20b. Place of Disposition 20b. Place of Disposition State	ematory or other place)		Location - City or To	own, State
Baltir	permit. Pages 1 Department of H important: if ite any injury or ot		21. Signature of Funeral Service Licensee	22. Name and Address of Facility CGuire Funeral Serv 400 Georgia Ave., N		.ngton, D.	
	Physician /Medical		23a. Part Enter the disease, or complications that caused the death. Do not enshock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Atherosclerotic Due to (or as a consequence of):		respiratory arrest,		Approximate Interval Between Onset and Death
8760,	death certificate be executed as eattending physicien and ider use as the burial-transit	Ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of):				
O. Box 6	death certifii e attending p od for use as	Physician/Medical		□Ectopic pregnancy □ Other (specify)		23d. Date of delive Month	ery Day Year
ords, P.	w requires that the been signed by th should be detache	þ	Part II. Other significant conditions contributing to death but not resulting in the Coronary Artery Disease Hypertensic			o use contribute to the 2 No 3 □ Prob	he cause of death?
of Vital Records,	The law ste has b page 2 s	e Completed	Cerebrovascular Accident, Seizure I	Disorder 26. Place of Death	24a. Was an autopsy performed? 1 Yes X N	prior to co	opsy findings available impletion of cause of
ion of Vi	Phys this al dii	ertification: To B	examiner? 1 Yes 2 X No	ent 3 DOA Other: 4 Nursing Hom of 28c. Injury at 2	ne 5 Residence		<i>y)</i>
Division	of in	0	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, s building, etc. (Specify) 29a. Certifier 1 ☒ Certifying Physician: To the best of my knowledge, dea	,	8f. Location (Street: City or Town, Sta	nte)	
}	To the Hospital within 24 hours a To the Funeral Completely filled	Medica	(Check only one) 2 Medical Examiner: On the basis of examination and/or and manner stated. 29b. Signature and title of certifier		ed at the time, date a		Day, Year)
	118		30. Name and address of person who completed cause of death (Item 23a) (Type		11216764	4551 518005	20017
	Sta Registr		NOV 0 4 2004	Sports			

State of Maryland / Department of Health and Mental Hygiene

			1- State of Maryland / Dep	ertificate of Death	Mental Hygiei Rag.	ne ,
	Physici /Medic		Decedent's Name (First, Middle, Last)	REDHOFF	2. Date of Death Month November	2004 36755 9:27 P.M
	Examin		4a. Facility Name (If not institution, give street and number) 5507 Trent Street	4b. City, Town, or Location of Deat Chevy Chase		4c. County of Death Montgomery
	Funeral Director		5. Social Security Number 124–18–8913 6. Sex 1 7. Age (In yrs. last birthday) 1 7. Age (In yrs. last birthday) 1 7. Age (In yrs. last birthday) 1 83	Months Days Hours Min.	8. Date of Birth Month Day, Ye. July31, 19	9. Birthplace (State or Foreign New York, NewYor
poelveM edithiw the board	Sa-f show	ctor	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or town of the Maryland Montgomery Cheville Cheville County 10c. City, Town or town of the Cheville Chevil	ocation y Chase		10d. Inside City Limits M∑Yes 2 ☐ No
4. 4.	23e or 2 st be no	al Director	10e. Street and Number 5507 Trent Street	10f. Zip Code 20815	10g.	Citizen of What Country? United States
	il, or items	by Funeral	11. Marital Status 1 Never Married Married 1 Never Married Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married Divorced 12. Was Decedent Ever in U.S. Armed Forces? 12. Was Decedent Ever in U.S. Armed Forces? 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent Ever in U.S. Armed Forces? 14. Was Decedent Ever in U.S. Armed Forces? 15. Was Decedent Ever in U.S. Armed Forces? 15. Was Decedent Ever in U.S. Armed Forces? 17. Was Decedent Ever in U.S. Armed Forces? 17. Was Decedent Ever in U.S. Armed Forces? 17. Was Decedent Ever in U.S. Armed Forces? 17. Was Decedent Ever in U.S. Armed Forces? 17. Was Decedent Ever in U.S. Armed Forces? 17. Was Decedent Ever in U.S. Armed Forces? 17. Was Decedent Ever in U.S. Armed Forces?	Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puer 1 ☐ Yes 2√2 No Specify:	pecify Yes or No- o Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White
d Z I Z I 3-0036	ital Hygiene. do other then "neturel", or items 23e or 28e-f show event, if e Medical Ever it ret must be redified at	Completed	(Specity only highest grade completed) (Giv	edent's Usual Occupation e kind of work done during most of wo DO NOT use retired)	rking	. Kind of Business/Industry
	d other then '	Be Co	17. Father's Name (First, Middle, Last) Morris Bredhof:	18. Mother's Na	ne (First, Middle, Maid	den Sumame)
Maryla	h and Mentali 7 is marked reumatic ev	욘	19a. Informant's Name/Relationship (Type, Print) 19b. Mai	ling Address (Street and Number or Ric 7 Trent Street Che		
TOTE, I	Department of Health and Mental Importent: If Item 27 is marked any injury or other treumatic events.		20a. Method of Disposition 20b. Place of Disposition	osition (Name of	Date 20c.	Location - City or Town, State Falls Church, Va.
Baltimor	Departme Importer any injur		21. Signature of Funeral Service Licensee	22. Name and Address of Facility Conald V. Borgward	t Funeral	
Р	hysician		23a. Part1. Enter the disease, or complications hat caused the death. Do not en shock, or heart failure. List only one caulle on each line. Immediate Cause (Final Hypoxemia	nter the mode of dying, such as cardia	or respiratory arrest,	Approximate Interval Between Onset and Death minutes
	/Medical xaminer		resulting in death) Due to (or as a consequence of): Endstage COPD Sequentially list conditions.			
perinted	and I-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Uis ass or injury that initiated events resulting in death) Last Due to (or as a consequence of): c. Due to (or as a consequence of):			
od/oU,	physician and is the burial-transit	edicai E	d			
Sod .	attending for use a	hysician/Me		□Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Day Year
Cords, P.O.	been signed by the should be detached	by P	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacc	o use contribute to the cause of death? 2 ☑ No 3 ☐ Probably 4 ☐ Unknown
The law	ate has	Completed			24a. Was an autopsy performed 1 Yes 2 1	
DIVISION OF VITAL	within 24 hours after death. To the Funerel Director: After this certific completely filled in by the funeral director.	ertification: To Be	25. Was case referred to medical examiner? 1 Yes 2X No 27. Manner of Death 1 Natural 5 Pending Investigation 3 Suicide 6 Could not be	ont 3 DOA Other: 4 Nursing Hof 28c. Injury at Work? M 1 Yes 2 No	ath (Check only one) ome 5 X Residence 28d. Describe how in	jury occurred
UIVI Pital or A	ours after o	O	4 Homicide determined 288. Place or injury - At nome, rarm, s building, etc. (Specify)	th occurred at the time, date and place	City or Town, Sta	(s) and manner as stated
the Ho	hin 24 h the Fur npletely	Medical	(Check only 2 Medical Examinar: On the basis of examination and/or i and manner stated.	nvestigation, in my opinion, death occu	rred at the time, date a	and place, and due to the cause(s)
+	19 8 2 8		29b. Signature and title or Bertitier Jelene Hausen on	D22599		Date signed (Month, Day, Year) November 3, 2004
	100		30 Name and address of person who completed cause of death (Item 23a) (Type Ylene Larsen, M.D. 5530 Wisconsin Av		Chase, Mar	yland 20814
	Sta Registr		31. Date filed (Month, Day, Year) NOV 0 4 2004 32. Registrar's Signature	South		

			For State	State of	Marylan				ealth a	and M	ental Hy	giene,	200	L	36756
	Physici	an	Registrar Decedent's Name (First, Middle	, Last)							2. Date of De Month	ath Day		ar	3. Time of Death
	/Medic Examin	cal	Barbara Ann Ba 4a. Facility Name (If not institution,		ber)		4b. City	, Town, or	Location o	of Death	Noven	4c.	2,200 County of D	eeth	1:30 A. ™
		3 j	6904 El Paso S					Lando		24 Hea	0.0(D)		nce G		
	Funeral Director		5. Social Security Number 220–40–5451	6. Sex 7 1 ☐ M 2 反 F	Age (In yrs. 63	Yrs.	Months		Hours	Min.	8. Date of Bin (Month, Da 9/25)	y, Year) 41		Country	ce (State or Foreign y) inia
	pur *		Usual Residence of Decedent 10a. State 10b. County		10c. Cit	y, Town or Lo	ocation							100	d. Inside City Limits
	Aaryli f sho	ō	Md.	P.G.		Т.	andov	ær							1 Yes 2 □ No
	28a-	Director	10e. Street and Number	1.0.				p Code				10g. Citiz	zen of What	Country	y?
	3a or		6904 El Paso	Street					20785	5			U.S.A	•	
	death	Funeral	11. Marital Status	12. Was Deced	dent Ever in U	.S. 13.	Was Dece	edent of H	ispanic Orig	gin? (Spe	ecify Yes or No Rican, etc.)		14. Race - A	mericar	n Indian,
20	within 72 hours after death with the Maryland liene. Then "natural", or Items 23a or 28a-f show the Madical Examena must be natified a	by Fu	1 ☐ Never Married 2 € Marri 3 ☐ Widowed 4 ☐ Divorced		2 ∕∑ No	1	1 🗆 Yes		Specify:	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			Specify:	Afr: Ame:	ican- rican
212-0030	hour		15. Decedent			16a. Dece	dent's Usu	Jal Occup	ation			16b. Kir	nd of Busine		
Ò	nin 72 n na	Completed	(Specify only highes Elementary/Secondary (0-12)		4or 5+)	(Give	kind of wi DO NOT	ork done d	during most	t of worki	ng				,
7	d with	E O	Elementary/Secondary (0-12)	2 yrs.		Adm	ninst	.Cle	ck			Vet	erans	Adm	inistratio
2	e filed at Hygic I other vent, I	Be	17. Father's Name (First, Middle,	ast)							(First, Middle,	Maiden	Sumame)		
<u>a</u>	should be nd Mental marked o	T0	Charles Jones								Rose				
Maryland	0 0 0		19a. Informant's Name/Relationsh Norman U. Baker				•				lover, l		Town, State 20785		code)
	1 and Health iem 27 sther ti		20a. Method of Disposition	7114554414	20b. F	Place of Dispo	osition (Na	me of			ate		cation - City	or Town	n, State
و	permit. Pages Department of I Importent: If its any injury or o		15 Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Se		tate	cemetery, cre				ام ماد	11/6/0	4 т.	ourol	МА	
Baitimore,	artme		21. Signature of Funeral Service		Ma	- 2	2 Name a	nd Addres	ss of Facilit	v	11/6/0			Ma	•
ŭ	Dep Impo		X any	W.C	1 att		H.S.	Washi	ingtor	1 & S	Sons Co N.E.,	.,Ind	D.C.	20	019
			23a. Part1. Enter the disease, or	complications that ca	used the deat								<i>D</i> , 0	A	Approximate nterval Between
다 전	Physician		shock, or heart failure. List Immediate Cause (Final		.cular	Tampho	ma								Onset and Death
* *	/Medical		disease or condition resulting in death)	u	or as a consec		ına							-	
	Examiner	£	Sequentially list conditions	b. Renal	Failu	re									
26(0)	ם ב	lner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (d	or as a consec	quence of):									
	and and I-trans	Examlner	Cause (Disease or injury that initiated events resulting in death) Last	c. Hyper	tensio	n uence of):			-						
/60,	death certificate be executed eathoring physician and of for use as the burial-transit	dlcal E			's Dis										
28	ficate g physis the	edlc		0. 01012											
XOR	eath certifica attending ph I for use as th	n/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, out	ome of pregnant		∃Ectopic r	oregnan cu				2	23d. Date of	,	
n	death	Physician/Med	in the past 12 months? 1 Yes 2 No		ant at time of o		Other (s						Month	D	ay Year
J.	at the de d by the a etached	Phy	9 Unknown Part II. Other significant condition	1		udine in the c	do sh iin o		on in Bart I		23a Did t	obacco u	ea contribut	n to the	cause of death?
က်	The law requires that the stee has been signed by thoage 2 should be detached.	by	Part II. Other significant condition	is contributing to de	ath but not res	salang in the t	maenymg	Cause giv	on in raiti.			Yes 2[oly 4 Unknown
Records,	w require been sig should b	Completed									24a. Was	an	24h Were	autons	sy findings available
ğ	has ge 2	I du						-			autor	rmed?	prior	to comp	oletion of cause of
			25. Was case referred to medical						26 Place	of Death	1 ☐ Yes	2 2 No	101	es 2	□ No
5	ysicien: The las certificate hadirector, page	To Be	examiner? 1 ☐ Yes 2 ☑ No	Hoopital	npatient 2	ER/Outpatie	nt 3□ D	Oth	or:		me 5 Resi		S ∏Other (S	(pecify)	
ō	ding Phys		27. Manner of Death	28a. Date o		28b. Time o		28c. Injur Wor			28d. Describe			,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
0		atlo	1 Natural 5 ☐ Pendin 2 ☐ Accident investig	9	i, Day Todi)	injury	М		Yes 2 🗆	No					
Division of Vital		Certification:	3 ☐ Suicide 6 ☐ Could I 4 ☐ Homicide determ	ined 289. Place	of Injury - At h		reet, facto	ry, office			28f. Location (City or To			Rural F	Route Number,
	Hospitel o		20a Conffice	a Dhuai-i T	host of entities	oulodes de	th account	d at the t	no data s-	d place	and doos to the	031/07/=	and mass	200 51-1	and
	To the Hospitel or within 24 hours after To the Funerel Discompletely filled in	edical		g Physician: To the Examiner: On the ba and mann	sis of examina										
	To the within 2 To the complet	Me	29b. Signature and title of certifie				29	9c. Licens	e number	_		29d. Dat	e signed (Me	onth, Da	ay, Year)
		2>	+ Kupa	A Ila	1110	ins		04	221	1		Nove	mber (5,20	004
0	(4) 1°	7	30. Name and address of person	who completed cause	e of death (Ite	m 23a) (Type	, Print)	//)	1					
	0		Rupa A. Van			122	21 Me	rcant	ile I	ane,	Largo,	Md.	20774	1	
	St Regist	ate	31. Date filed (Month, Day, Year)		egistrar's Sign	ature	A. 1								

		•	1 - For State Registrar	State of Maryland	•	artment of F			giene Rog. Nd)	יחחו.	20	7 = 7
ı	Physici	an	Decedent's Name (First, Middle, Lass Name of the Management of the Manageme					2. Date of Dea Month	Dav	Year Year	S. There of	Dath
	/Medic Examin	al . er	Naronia Mae 4a. Facility Name (If not institution, give 3217 Prince Ran			4b. City, Town, o	r Location of D		4c. (2004 County of Death ince G	7:00 eorge	
	Funeral Director	\$	370-30-0210	- · · · · · · · · ·	a <i>st birthday)</i> 3 2 Yrs.	If Under 1 Year Months Days		1 1 - 2 1 -	h Y 92')	9. Birth Cout	place (State of	orForeign olin
	e-f show	ctor	Usual Residence of Decedent 10a. State 10b. County Prince		, Town or Lo		tville				10d. Inside C	City Limits
	h with the 23s or 28	al Director	10e. Street and Number 3217 Prince Ra	nier Place		10f. Zip Code	20747		10g. Citiz	en of What Cou	ntry?	
0000	s filed within 72 hours after death with the Maryland I Hygiene. other than "netural", or Items 23s or 28e-f show yent. It a Medical Experimet. Mat be notilised at	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:			lispanic Origin? an, Mexican, Pi Specify:	(Specify Yes or No- uerto Rican, etc.)		4. Race - Ameri Black, White, Specify:		k
0-617	within 72 hor ene. than "netura the Modical E	Completed	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12)		(Give life. L	lent's Usual Occup kind of work done DO NOT use retired	during most of d)	working		ud of Business/In	ŕ	
and z	ed at b	Be	17. Father's Name (First, Middle, Last)	nner		Unknown		Name (First, Middle, ne Gari	Maiden S			
Maryi	ges 1 and 2 should be not of Health and Menta if item 27 Is marked or other traumatic events.	2	19a. Informant's Name/Relationship (7 Adline Tatum/ N	ype, Print)				r Rural Route Number				
saumore,	t. Pa rtmer rtant rjury		20a. Method of Disposition 1 **SBurial 2 Cremation 3 **Donation 5 Other (Specify	Removal from State	emetery, cren Sh. Na	sition (Name of natory or other place at 1 Cer	n. 11	Date - 8 - 0 4	Sui	tland,	MD	
D D	Depar Impore eny ir		21. Signature	jl-		722 Nort	th Cap	aylor's itol St.	NW	eral H Washi	ngton	
	Frrysician /Medical Examiner		236. Part1. Enter the disease, or come shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	aDue to (or as a consequ	0/			LUNG		348	Approximal Interval Bet Onset and	tween
ć	eath certificate be executed attending physician and for use as the burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence) Due to (or as a consequence)								
09/89	certificate be nding physici use as the bu	edical	•	d								
O. Box	D O D	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ ₹₹₹0 9 ☐ Unknown	23c. If yes, outcome of pregna 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of de 9 □ Unknown	death 3	Ectopic pregnancy Other (specify) _	<u>'</u>		2:	3d. Date of delive Month		Year
ords, P.	w requires that the de been signed by the a should be detached f	by	Part II. Other significant conditions o	- 1	ulting in the u	nderlying cause giv	en in Part I.			se contribute to t		
al Records	The law ate has b page 2 s	Completed								24b. Were auto prior to co death? 1 ☐ Yes	mpletion of a	available ause of
VItal	Physician: Th this certificate ral director, pag	o Be	25. Was case referred to medical examiner? 1 Yes 2 10	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatien	it 3□ DOA Oth	on	Death (Check only o		Other (See	64)	
on or	ding h. After fune	tlon: To	27. Manner of Death 1 ✓ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injur Wor		28d. Describe h			Y)	
DIVISION	i Dir	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At ho building, etc. (Specify	me, farm, str	eet, factory, office		28f. Location (S City or Tox		Number or Rura	ul Route Num	nber,
	o the Hospital or Al ithin 24 hours after o the Funeral Direc ompletely filled in by	edical (ysician: To the best of my knowniner: On the basis of examination and manner stated.								s)
	To the within 2 To the Comple	Ň	29b. Signature and title of confrier	Un Shu	Dur	29c. Licens	e number	9	29d. Date	signed (Month,	Day, Year)	
P	- 3			iggs-Shipman	117		sville	Dr. Su	ite	100 Be	ltsvi	ille
	Sta Regist	ate rar	31. Date filed (Month, Day, Year) NOV 0 8 2004	P. Registrar's Signa	ture				_			
DH	IMH 17 Rev 1/2	2001			-							

Amend item#25, 27, 28a-e, per HE, C837, III/17/04 III
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. 2001 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 13, Month Physician 5:00 A M BUTLER August 2004 JOHN MORRIS /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Frederick Frederick Memorial Hospital Frederick If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1⊠M 2□F Director 59 197-34-4317 AUG.18.1944 OHIO Usual Residence of Decedent 10a State 10c. City, Town or Location 10b. County 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Madical Examinar must be notified at 1 ☐ Yes 2 No Director FREDERICK **EMMITSBURG** 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? U.S.A. 16850 EYLERS VALLEY ROAD death 21727 Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status e filed within 72 hours after if Hygiene. other than "natural", or Ite 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No þ Specify: WHITE 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) CONSTRUCTION 2 SUPERINTENDENT permit. Pages 1 and 2 should be filk Department of Health and Mental Hy Important: If Item 27 is marked other any injury or other traumatic svent. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) JANE ANN SWEENEY MOORIS COOKE BUTT.ER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 16850 EYLERS VALLEY ROAD, EMMITSBURG, MD. 21727 BUTLER/WIFE ANNE F. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State * 4 □ Donation 5 □ Other (Specify) SMITHSBURG CREMATORIUM 8/17/2004 SMITHSBURG, MD.21783 21. Signatur o Funeral Service Licensee 22. Name and Address of Facility SKILES FUNERAL HOME 210 W. MAIN ST., EMMITSBURG, MD. 21727 Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate sheck or heart failu Immediate Cause (Final disease or condition resulting in death) Interval Between Onset and Death Enysician W. LEXAMINE Y MEDICAL EXAMINE Subdural Hematoma /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner transit and Due to (or as a consequence of) as the burialphysician P.O. Box 68760 Physician/Medical the attending esn IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 1 Live birth 2 ☐ Fetal death in the past 12 months? Month Day Year 4☐ Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, à pe 1 Yes 2 No 3 Probably 4 Unknown Completed Polyarteritin 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Seizure dijorder 1 ☐ Yes 2 ☐ No 3 No 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner Hospital: 1 ☑Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 X Yes this 28c. Injury at Work? 27. Mannal of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: After or Attanding 5 Pending unknown M unknown 1 ☐ Yes 2 🙀 No within 24 hours efter death. To the Funeral Director: A investigation 2 Accident Recurrent falls 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) unknown 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by t 4 - Homicide unknown the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Day, Year) D0047679 113/2004 Mys MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) F. Gregory Grillo GOY Solaver Cut # 103 MD Frederick, MD Zito3 31. Date filed (Month, Day, Year) NOV 1.7 32. Registrar's Signature State 2004 Registrar

Amend i Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Roberta Ann Phillips Burbage 2,2004 October /Medical 4a. Facility Name (If not institution, give street and number, 4c. County of Death 4b. City. Town, or Location of Death **Examiner** Medical Conta REGIONAL SALISBUR NICONICO TENINSULA If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Months Hours Min 1 □ M 2 🔽 F 220-28-4798 Director MD Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits item 27 is marked other than "neturel", or items 23a or 28a-f show other treumatic event, the Medical Exame or must be a velified at 1 ☐ Yes 3 ☐ No Director MD Worcester Berlin 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6906 Libertytown Rd. 21811 US 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ☐ Yes 2 No Yes, Give 1 Never Married 2 ★ Married 1 ☐ Yes 2 No Specify: Specify: White þ If Yes, Give Year or Dates: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Roberta Burbo Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed with Department of Health and Mental Hygiene important: if item 27 is marked other that eny injury or other treumatic event, 1 to 2008. 12 Owner Operator Poultry Farm 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Charles Phillips, Sr. Hilda Layton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William T. Burbage (son) 6908 Libertytown Rd., Berlin, Md. 21811 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State

'4 ☐ Donation 5 ☐ Other (Specify) Burbage Family Cem. 10-5-04 Libertytown, Md. 22. Name and Address of Facility The Burbage Funeral Home 21. Signature of Funeral Service Licensee 7 1 108 William St., Berlin, Md. 2

231. Part 1. Enter the disease, or complications that deuted the peath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 108 William St., Berlin, Md. 21811 Approximate Interval Between Onset and Death Immediate Cause (Final Physician cerebra henorrhage disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner. CER CATION APPROVED BY MEDICAL EXAMINER Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-transit Due to (or as a consequence of): physician Box 68760 certificate be Physician/Medical the use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Year Day 4 Pregnant at time of death 5 Other (specify) P.0. 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ρ breast 1 Yes 2 No 3 Probably 4 Unknown Completed Left Thombosis vendus 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an Coumadin therapy 21 No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 XYes -3 No 1 Inpatient 0 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred e Hospitel or Attending P. 24 hours after death. Evenue of Funerel Director: After to Certification: After 1 Natural
2 Accident 5 Pending investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospitel within 24 hours a To the Funerel D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Peninsula Regional Medical Center Salisbury, MI) no completed cause of death (Item 23a) (Type JV MUS hartes Nia

DHMH 17 Rev 1/200

State Registrar 31. Date filed (Month, Day, Year)

NOV 1 7 2004

32. Registrar's Signature

			1 - For State Registrar	State of Maryland	d / Depa		Health and	Mental Hyg					
			Decedent's Name (First, Middle, Last)		imodic or	Death	2. Date of Dea	leg. No:2 0 0 4	36760			
	Physici		Carolyn Eliza					Nov.	Day Yeer	6 . 20 A M			
	/Medi Examir		4a. Fecility Name (If not institution, give			4b. City. Town.	or Location of Dea		2, 2004 4c. County of Deat	6:30 A M			
	Lxaiiii	iei	11815 Wildcat H				yersvil		Freder				
	Funeral		Social Security Number 6. Se	x 7. Age (In yrs. la	ast birthday)	If Under 1 Year	If Under 24 Hrs	S R Date of Bigh	0.8:4				
	Director		220-54-4306	^{3 M 2} √2 F 5 4	Yrs.	Months Days	Hours Min	Dec. 1	$7^{(9ar)}$ 1949 $^{(6)}$	thplace (State or Foreign buntry) MD			
	D		Usual Residence of Decedent										
	arylar show	_	10a. State 10b. County		, Town or Lo					10d. Inside City Limits			
	Ba-f	cto	MD Frede	erick	Мує	ersvill	e			1 ☐ Yes 2X No			
	within 72 hours after death with the Maryland ene. than "natural", or items 23e or 28e-f show I.a Micalcol Eserial er mast be swithed at	Completed by Funeral Director	10e. Street and Number 11815 Wildcat	Рd		10f. Zip Code	1773	1	log. Citizen of What Co	•			
	s 23	rai			140				US				
	ltem	L.	11. Marital Status	12. Was Decedent Ever in U.S Armed Forces?	5. 13.	Mas Decedent of I f Yes, specify Cub	an, Mexican, Puer	Specify Yes or No- rto Rican, etc.)	14. Race - Ame Black, White				
36	irs af	by	1 Never Married 2 Married 3 Widowed 4 Divorced	1 □Yes 2 □No If Yes, Give X Year or Dates:		1□Yes 2∏ No	Specify:		Specify: [J	hite			
ŏ	2 hou	ed	15. Decedent's Edu		16a. Deced	dent's Usual Occur	pation		16b. Kind of Business/				
2	n un 7	pie	(Specify only highest grad	e completed) College (1-4or 5+)	(Give life. l	kind of work done DO NOT use retire	during most of wo	orking					
7	d with	E O	Elementary/Secondary (0-12)	College (1-401 34)	col1	ections	s offic	er	banking				
덛	oth oth		17. Father's Name (First, Middle, Last)					me (First, Middle, I	Maiden Sumame)				
<u> a</u>	Venta Venta	To Be	Jesse M. Clary	Sr.			Myrt.	le Wrigh	nt				
Maryland 21215-0036	and /		19a. Informant's Name/Relationship (T)	pe, Print)					City or Town, State, Z				
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural; or items 23a or 28a-f show any injury or other traumatic event, the Medical Eran instrument by Landon and ODGs.		Dale Bidle (Hus	·	Andrews or an income			, Myersy	ville, MD	21773			
Baltimore,	of H of H if itan	1 3	20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ F	lemoval from State	ace of Dispo metery, cren	sition (Name of natory or other pla	сө)	Date	20c. Location - City or	Town, State			
Ē	Pages ment of I ant: If its lury or o		' 4 □ Donation 5 □ Other (Specify)	Lu	thera	n Cemet	ery 11.	/6/04 I	Middletow	n, MD			
<u>sa</u>	Depart Import any in		21. Signature of Funeral Service Dicens	118	²²	Name and Address	ss of Facility Thoma						
ш_	205 2 3	16. 1	()	1401	3	1 E. Ma	in St.	Middle	neral Hom etown, MD	21769			
9			23a. Part1. Enter the disease, or compl shock, or heart failure. List only or	cations that caused the death.	Do not ente	er the mode of dyn	ng, such as cardia	c or respiratory arre	est,	Approximate Interval Between			
	Physician	0.0	Immediate Cause (Final disease or condition	Atheroso	lest	iz Car	Guznul	Lan Disc	ase	Onset and Death			
	/Medical Examiner		resulting in death)	Due to (or as a conseque									
	Lxammer	L	Sequentially list conditions,	o									
	sit s	ine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a conseque	ence of):								
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760,	ate be executed hysician and the burial-transit	calE		Oue to (or as a conseque	erice or).								
	physicate s the			l				-					
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Вох	atten for u	ian	in the past 12 months?	1 Live birth 2 Fetal of 4 Pregnant at time of dea	death 3 🗆	Ectopic pregnancy	1		23d. Date of deliver Month	very Day Year			
o.	he de	ysic	1 □ Yes 2 ☒ No 9 □ Unknown	9□ Unknown	aun ɔഥ	Other (specify) _							
مز	The law requires that the death certifica site has been signed by the attending ph bage 2 should be detached for use as th	by Physician/Med	Part II. Other significant conditions con	tributing to death but not resul	ting in the ur	iderlying cause giv	en in Part I.	23e. Did tob	acco use contribute to	the cause of death?			
ds	uires sign ld be	d b	Smoking			, , ,		1 ₫ Ye	s 2□No 3□Pro	bably 4 Unknown			
Ö	w require been sig should b	Completed	14	2				-					
Že K	has ge 2 s	E G	Hyzertenseo	1,7				24a. Was ar autops perform	y prior to co	opsy findings available ompletion of cause of			
			05 111					1 ☐ Yes 2		2 No			
Vital Records,	iding Physician: th. After this certifical funeral director, ic	o Be	25. Was case referred to medical examiner?	ospital:	5.0	3 DOA Oth		ath (Check only one					
ō	Phys r this ral di	\vdash	1 Yes 25 No	1 Inpatient 2 E	R/Outpatient 28b. Time of	28c. Injur	4 Li Nursing F	lome 5 Reside	nce 6 Other (Speci	(fy)			
o	ding th: Afte	tio	Natural 5 Pending 2 Accident investigation	(Month, Day Year)	Injury	Wor	k? Yes 2 □ No	200. 2000.100 (10	Winjary Goodfred				
Division	Atten deal ctor	fica	3 Suicide 6 Could not be	28e. Place of Injury - At hom	ne, farm, stre			28f. Location (Str	eet and Number or Rur	ral Route Number			
É	after after Dire	Certification;	4 Homicide determined	building, etc. (Specify)		7,		City or Town	, State)				
	spite hours nera y fille		29a. Certifier 1 Certifying Phys	sicien: To the best of my know	ledge, death	occurred at the tir	ne, date and place	, and due to the ca	use(s) and manner as :	stated.			
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifical completely filled in by the funeral director.	edical	(Check only 2 Medical Exeminate)	ner: On the basis of examination and manner stated.	on and/or inv	estigation, in my o	pinion, death occu	irred at the time, da	ite and place, and due t	to the cause(s)			
	To t To th	Σ	29b. Signature and title of certifier			29c. Licens	e number	29	d. Date signed (Month,	Day, Year)			
			· Waves	- mo		De	05872	26	11/5/04				
	3 %		30. Name and address of person who co		23a) (Type, F	Print)			B * - 1				
	10		Parkerian Mederal		morrise	Ct. De	ersville	imo =	21773				
	Sta Registr	-	31. Date filed (Month, Day, Year)	32. Registrar's Signatu	re	4 1							

04-07017 Joseph Brown

			1- For State of Maryland / Department of Registrar Certificate			ne No 0 0 1.	26761
	Physici	an	1. Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day Year	CO TOO of DOOR!
	/Medic	al	Joseph T. Brown Sr. 4a. Facility Name (If not institution, give street and number) 4b. City. To	wn, or Location of Death	October	30, 2004 4c. County of Death	19:34 M
4	Examin	ier		apolis		Anne Aruno	del
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Y		8. Date of Birth (Month, Day, Ye	9. Birth	place (State or Foreign
	Director		213-32-6808 TSM 2DF 66 Yrs.		Dec. 25	1937 Mai	
	yland 10w		10a. State 10b. County 10c. City, Town or Location				IOd. Inside City Limits
	e Mar	ctor	Maryland Anne Arundel Annapolis				1 ⊈Yes 2 ☐ No
	vith th	Dire	10e. Street and Number 10f. Zip Co	de	10g.	. Citizen of What Cou	ntry?
	eath v	erai	1908 F Copeland Street 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent	21401	ecify Yes or No-	USA 14. Race - Ameri	can Indian.
ပ္	or item	by Funeral Director	1 Never Married 2 Married 1 Yes 2 No	t of Hispanic Origin? (Spe Cuban, Mexican, Puerto I	Rican, etc.)	Black, White,	
003	72 hours after death with the Maryland Insture!; or Items 23e or 28e-f show Ideal Exaint art must be codified at	d by	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:	No Specify:		Specify: B1	ack
21215-0036	n 72 h	Completed	life. DO NOT use r	fone during most of worki	ng 16t	b. Kind of Business/In	dustry
212	d withi	ошь	Elementary/Secondary (0·12) College (1·4or 5+) 1 Oth O Baker's A	•	ι	ıs Naval	Academy
	al Hyg	Be	17. Father's Name (First, Middle, Last)		(First, Middle, Mai	iden Surname)	
Maryland	2 should be filed within 72 hours and Mental Hygiene. Is marked other than "naturel", reumatic event, the Medical Exa	To	Theodore Brown	Ann Har:		*****	0-4-1
Ma	s 1 and 2 should be filed within 72 hours after death with the Marylar of Health and Mental Hygiene. Item 27 is marked other than "naturel", or Items 23e or 28e-f show other treumatic event, the Medical Examination and interest including a second of the confilled at the comments of the confilled at the comments of the confilled at the confilled	1 8	Manager services	treet and Number or Rura		US- 65	,
ē,	s 1 ar of Hea Item 3		20a. Method of Disposition 20b. Place of Disposition (Name cametary, crematory or other	r place)	Date 200	c. Location - City or To	own, State
imo	Pages nent of ent: If It ury or o		**B'Buriai 2 Cremation 3 Removal from State **4 Donation 5 Other (Specify) **Removal from State Bestgate Memo	ria1 11/5	/04 Ar	napolis,	Md.
Baltimore,	permit. Pages 1 and 2 s Department of Health ar Importent: If Item 27 is any injury or other treu		21. Signature of Funeral Service Licensee 22. Name and A	ddress of Facility	s Mortus	arv DA	
	402 0		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode or	ese & Sons			01 Approximate
1	Physician		shock, or heart failure. List only one cause on each line. Immediate Cause (Final	1	,		Interval Between Onset and Death
1	/Medical		disease or condition resulting in death) a. The Garage was a consequence of the control of	03			
	Examiner		Sequentially list conditions, b.				
	nsil	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury				
o,	execu an and rial-tra	Exal	that initiated events c. resulting in death) Last Due to (or as a consequence of):				
8760,	ate be executed hysician and the burial-transil	dical	d				
9	that the death certific ed by the attending p detached for use as t	/Mec	IF FEMALE: 23c. If yes, outcome of pregnancy			22d Date of deliv	
Вох	death of atten	by Physician/Me	200. Was decement pregnant in the past 12 months? 1 \[\text{Live birth} \ 2 \] Fetal death \[3 \] Ectopic pregnant at time of death \[5 \] Other (special birth) \[5 \] Other (specia			23d. Date of deliver	Day Year
P.O.	at the oby the	hys	9 Unknown				
	es be		Part II. Other significant conditions contributing to death but not resulting in the underlying cause	e given in Part I.	23e. Did tobac	co use contribute to t	
Vital Records,		Completed			24a. Was an	7,1	
Rec	The law te has b	dmo	L		autopsy performed	prior to co death?	psy findings available mpletion of cause of
ita	(0	Be Co	25. Was case referred to medical	26. Place of Death	(Check only one)	No Yes	2 No
of V	Physicien: this certific ral director,	70 5	examiner? ¹XXYes 2 □ No Hospital: 1 □ Inpatient 2 X ER/Outpatient 3 □ DOA	Address of the Control of the Contro	me 5 Residence	e 6 Other (Specif	y)
o uc	ling P	ion:	The state of the s	Injury at 2 Work? 1 ☐ Yes 2 No	28d. Describe how i		
Division	Attending r death. ector: After by the fune	ficat	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, of		28f. Location (Stree	CVAS SHOT	il Route Number,
Ö	s after of Dire	Certification:	4 Homicide determined building, etc. (Specify)		City or Town, S	State) 1905 + CC	puland street
	To the Hospitel or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the fu	edical (29a. Certifier (Check only (Ch				
	To th Within To th compl	Me	29b. Signature and title of certified 29c. Li	icense number	29d.	Date signed (Month,	Day, Year)
)			y M. Ct	O.C.M.E.	0	ctober 31,	2004
			30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JACK M. TITUS M.D. 1111 Penn	Street, Balt	rimore M	arvland 21	201
	Sta	ate	31. Date filed (Month Day, Year) 32. Segistrar's Signature	STORY DUL	THE PARTY PARTY	LLY TORK ZI	-CUI
	Regist		NUV - 3 2004 1000 10 1000				

PM 4-07011 linton Blasky

	1		For State Registrar	State of Mar		artment of F			giene 10g. N 2 0 (14 36762
	Physici	an	1. Decedent's Name (First, Middle, La	,				2. Date of Dea Month	ith Day	3. Time of Death Year
	/Media	cal	4a. Facility Name (If not institution, giv	R. Blasky.		4b City Town o	r Location of Deal	Octobe	20, 20 4c. County	004 16:44 ^M
	Examir	ner	Saint Mary's Hosp			,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	rdtown		1	Mary's
	Funeral		5. Social Security Number 6. S	Sex 7. Age	(In yrs. last birthday)	If Under 1 Year Months Days			1	Birthplace (State or Foreign Country)
	Director		577-92-0488	MM 2□F 43	Yrs.	Wortins Days	Tiodis	12-9-1		Washington, DC
	land		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	ocation				10d. Inside City Limits
	Many First	į	Maryland Anne Aru	ındel		Edgewat	er			1 ☐ Yes 2 No
	th the	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of W	/hat Country?
	23e (23e (23e (23e (23e (23e (23e (23e (709 Londontown Ro	l.		2103	7		USA	
)36	be filed within 72 hours after death with the Maryland ital Hygiene. d other then "natural", or iteme 23e or 28e-f show event. I're Medical Evariling riust be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ev Armed Forces? 1 Yes 2 1 No If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 No	lispanic Origin? (§ an, Mexican, Puer Specify:	Specify Yes or No- to Rican, etc.)		e-American Indian, k, White, etc. White
Š	2 hou		15. Decedent's E (Specify only highest gr	ducation	16a. Dece	dent's Usual Occup	ation	orking	16b. Kind of Bu	siness/Industry
Z	ithin 7	Completed	Elementary/Secondary (0-12)	College (1-4or 5+))	kind of work done DO NOT use retired		irking		
Maryland 21215-0036	e filed withir al Hygiene. other then vent, tra M		12th 17. Father's Name (First, Middle, Last	1	Sheet	: Metal M		me (First, Middle,	Heating	
anc		Be C	Clinton Larry					el Rebeco		
<u> </u>	s 1 and 2 should be f f Health and Mental I ftem 27 is marked o other treumatic eve	2	19a. Informant's Name/Relationship (19b. Maili	ng Address (Street	-			
	2 = K =		Laurie D. Blasky	Wife	709 I	ondontow	n Rd., E	dewater	MD 210	37
č.	of Hea		20a. Method of Disposition		20b. Place of Dispe			Date		City or Town, State
Ĕ	Pages ment of I ent: If Its ury or o		1 Donation 5 ☐ Other (Special Control of Co		Lakemont	Cemetery	11–3	-04 I	Davidson	ville, MD
Baltimore,	permit. Pages Department of I Importent: If Its any injury or or		21. Signature of Funeral Service Lige	nsee,		2. Name and Addre	G			uneral Home er, <u>MD 21037</u>
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused the one cause on each line	ne death. Do not en	ter the mode of dyir	ng, such as cardia	c or respiratory arr	rest,	Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)	a CORONI		MINTSOS	15			5.1007 2.110 502.11
	/Medical Examiner	П	rossing in assuri		consequence of):	A 00 . 01/	\CQ \		0	
	4 4	ē	Sequentially list conditions, if any, leading to immediate	b. MAENOS C Due to (or as a	consequence of):	120 (O V)	25000124	DIZEL	26	-
	uted d ansit	Examine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	C						
oʻ	an an	Exa	resulting in death) Last	Due to (or as a	consequence of):					
8760,	icate be executed physician and s the burial-transit	dical		d					-	
ē ×	ding p	0	IF FEMALE:	23c. If yes, outcome of	nregnancy				30.1.5	
Rox	eath certiti attending I for use as	Physician/M	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 2 4 ☐ Pregnant at til	Fetal death 3	☐Ectopic pregnancy ☐ Other (specify)	1		23d. Date Mor	of delivery oth Day Year
j.	that the de led by the a detached	ysic	1 Yes 2 No 9 Unknown	9□ Unknown						
Records, P.	The law requires that the death certiticate be executed the has been signed by the attending physician and oage 2 should be detached for use as the burial-transit	by	Part II. Other significant conditions	contributing to death but	not resulting in the u	inderlying cause giv	en in Part I.			bute to the cause of death? 3 Probably 4 Unknown
၀ ၀	aw re	plet						24a. Was a		Vere autopsy findings available rior to completion of cause of
		Completed						perfor	med? d	eath2
Vita	sicien: Th certificate irector, pag	Be (25. Was case referred to medical examiner?					ath (Check only or	ne)	
<u>o</u>	this al di	2	1 X Yes 2 No	Hospital: 1 Inpatient			4 Nursing i	Home 5 Resid		
		lon:	27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day)	Year) 28b. Time o	Wor	yat k? Yes 2 □ No	28d. Describe n	ow injury occurre	9G
Division		ficat	2 Accident investigated 3 Suicide 6 Could not be determined	OP Place of laius	y - At home, farm, st					er or Rural Route Number,
2	P ¥ te	Certification:	4 Homicide determined	building, etc.				City or Tow	n, State)	
	To the Hospitel or Attenwithin 24 hours after deat To the Funerel Director: completely tilled in by the	edical C	29a. Certifier 1 Certifying Pl (Check only one) 2 Medical Exa	nysician: To the best of miner: On the basis of e	xamination and/or in	h occurred at the tire	me, date and plac pinion, death occ	e, and due to the c urred at the time, c	ause(s) and mar late and place, a	nner as stated. nd due to the cause(s)
	To the within To the Comp	Me	29b. Signature and title of certifier	. 0		29c. Licens		1	_	(Month, Day, Year)
			Makera !	me Kn.	ll		O.C.M.E.	(October	31, 2004
			30. Name and address of person who	completed cause of dea	111	Print) Penn Str	eet, Bal	timore, N	Maryland	21201
		ate	31. Date filed (Month, Day, Year)	32. Prigistrar	s Signature	1.0.				
	Regist	rar	NOV - 3	ZUU4 /	U B A					

V.S	. CHASO	N	For State		State of	Marylan					and M	ental Hy	giene	•			
			Registrar 1. Decedent's Name (Firs	t Middle Last)			Ce	rtificat	e of L	Jeath		2. Date of De	Reg. No	200	4	36	763
	Physici		Juan	i, Middle, Easi)	C.	Ch	acon					Month NOV •	Day		'ear	3. Nme	8 P ^M
	/Medic Examir		4a. Facility Name (If not in	nstitution, give s	treet and numb	er)		4b. City,	Town, or	Location of	of Death	1100.	_	County of	Death	143	8 P
	Zam		PRINCE GEC	RGES HO	SPITAL	CENTER	2	CI	HEVE	RLY]	PRINC	E GI	ORGE	S
	Funeral		5. Social Security Number		7. M 2 F	Age (In yrs.		If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Birt	h Va Year)	· E	Birthp	lace (State	e or Foreign
	Director		none Usual Residence of Dece		W 201	29	Yrs.					1/23/	197	5	Guc	l'Cema	ата
	land ow		10a. State 10b.	County			y, Town or Lo								1	0d. Inside	City Limits
	a-f sh	tor	MD Pr	cince (George	Ну	attsv	ille								1 □ Y€	es 2□No
	s 1 and 2 should be filed within 72 hours after death with the Maryland I Health and Mental hygiene. Item 27 is marked other then "naturel", or Items 23e or 28a-f show other traumatic event, the Medical Examinat must be notified at	by Funeral Director	7304 Rigg	gs Road	Apt.	103		10f. Zip 2	0783	3				izen of Wh uate			
	ems (iner	11. Marital Status	1	2. Was Decede Armed Force	ent Ever in U.	S. 13.	Was Deced	lent of His	spanic Orig	gin? (Spe	cify Yes or No- Rican, etc.)		14. Race -	Americ White,		
36	s afte	y F.	1 🔀 Never Married 2 3 ☐ Widowed 4 ☐ D		1 ☐ Yes 2. If Yes, Give	No No	1					temala		Specify:		nite	
21215-0036	turel	ed b		Decedent's Educ	Year or Date	95:	16a, Dece	dent's Usua	I Occupa	ition			16h Ki	ind of Busi	ness/In	dustry	-
215	hin 72 n "ng Media	piet	(Specify oni	ly highest grade	completed) College (1-4	or 5+)	(Give lite.	kind of wor DO NOT us	k done d e retired)	luring most	of workir	ng	100.10	1110 01 0031	1000111	addity	
2	ed with giene. er ther	Completed	12		College (1-4	01 34)	Roo	f co	ntra	acto:	r		Cor	nstr	uct	ion	
Maryland	12 should be filed v n and Mental Hygie 7 Is marked other t raumatic event, In	Be	17. Father's Name (First, Carlos Hun		Chaco	n					_	(First, Middle,		Sumame)			
7	hould d Mer marke matic	2	19a. Informant's Name/R			11	10h Mailie	a Addasas	(Street o			I Route Numbe		. T O1			
	and 2 s ealth an n 27 ls i		Alida Zuni									ville				Code)	
Baltimore,	ages 1 and 3 ant of Health it: If Item 27 y or other tra		20a. Method of Dispositio 1 □ Burial 2 □ Cre 1 □ Donation 5 □ 0	mation 3 Re	emoval from Sta	20b. P	lace of Dispo emetery crei n JO	sition (Nam natory or el	ne of her place luni	cipa	111	ate /07/04	^{20c.} Lo	cation - Ci	ty or To	wn, State 1ater	mala
Baltir	permit. Pages 1 Department of H Important: If Ite any injury or ot		- /	Service License	, °							FUNE					
			23a. Part1. Enter the disc shock, or heart failu	ease, or complic	ations that cau	sed the death								L Sp.	T 111	Approxim	ate
	Physician		Immediate Cause (Final disease or condition	ile. List Only On	e cause on eac	η	1 07-	T14	11	5	2	uni	61			Interval B Onset an	d Death
	/Medical		resulting in death)	(a.	Due to (or	as a consequ	uence of):			V/			مدر				
	Examiner	<u>.</u>	Sequentially list condition	ns, b.	Due to fee												
	ted nsit	Examiner	Sequentially list condition if any leading to immedia cause. Enter Underlying Cause (Disease or injury	ate 4	Oue to for	as a conse	neuce ori.										
<u>,</u>	execu n and ial-tra	Exar	that initiated events resulting in death) Last	C.	Due to (or	as a consequ	uence of):								-		
8760,	cate be executed bhysician and the burial-transit	dical		d.													
9		Nedi	IF FEMALE:														
Вох	death certific e attending p ed for use as	Physician/Me	23b. Was decedent pregr in the past 12 month	Tarri		n 2 ☐ Fetal	death 3	Ectopic pre					2	23d. Date o		ry Day	Year
0.	0 0 0	ysic	1 Yes 2 No		4□Pregnan 9□Unknowi	t at time of de n	eath 5□	Other (spe	ecify)					WORK		Day	real
<u>α</u>	£ 26 €		Part II. Other significant	conditions conf	ributing to deat	h but not resu	ulting in the u	nderlying ca	- Luse give	n in Part I.		23e. Did to	bacco u	se contribu	ite to th	e cause of	f death?
Records,	luires n sign	d by						, ,				1 🗆 Y	es 2	ZNo 31] Prob	ably 4	Unknown
S	law requas been 2 shoul	Completed										24a. Was a	/_	24b. We	re autor	osv finding	s available
Re	The la	omp						-				autop. perfor 1 1 Yes	med?	prio	r to cor th?	npletion of 2□No	cause of
Vital	(Q LL	Be C	25. Was case referred to	medical						26. Place	of Death	Ch k onl or	2□No ne	1	1 62	2 140	
of V	Physiclen: this certific al director,	To	examiner? 1∡ Yes 2 □ No	Ho	ospital: 1 🗆 Inp	atient 2 🔀	ER/Outpatien	t 3 🗆 DQ	A Othe	r: 4 🗆 Nu	sing Hor	ie 5 🗆 Resid	ence 6	3 □Other	Specify 1)	
	ng fter inei	ion:	27. Manner of Death 1. Natural 5] Pending	28a. Date of I (Month,	njury Day Ye <i>ar)</i>	28b. Time of Injury	28	Bc. Injury Work	?	L	8d. Describe h	ow injury	y occurred	Pic	1 FEL	LOK
Sio	Attending r death. sctor: After by the fune	icati	2 Accident 3 ☐ Suicide 6 ☐	investigation Could not be	11 1	10Y	133 2	_ M	\wedge	es 2 🗆 N	10	R ROOK	To	PANE	nen	7	
Division	after Direc	Certification:	4 Homicide	determined		etc. (Specify	1)					8f. Location (S City or Tow			9 6	LEEN!	SELT
_	ne Hospitel or Attendi n 24 hours after death. ne Funerel Director: A pletely filled in by the fu		29a. Certifier 1□ C	Certifying Physi	cian: To the be	T PEPAG est of my know	wledge, death	occurred a	at the time	e, date and	d place, a	nd due to the o	ause(s)	and mann	er as st	ated.	
	n 24 ł n 24 ł he Fu	edicai	(Check only 2XXV one)	ledical Examin	er: On the basi and mapher	s of examinat stated.	ion and/or in	estigation,	in my opi	inion, deat	h occurre	d at the time, o	ate and	place, and	due to	the cause	(s)
	To the within 2 To the complet	Σ	29b. Signature and title of	certifier					License			2		e signed (f			
•	3	λ	> //	1	16	5			0.C.	M.E			NO'	V. 2	, 2)04	
	1)	30. Name and address of	person who con	npleted cause of	of death (Item	23а) (Туре, 1 Ре пп	Print) Stre	et,	Balti	more	, Mary	and	2120	1		
	Sta	to	31. Date filed (Month, Da	x Year)	32. Regi	istral's Signat						,					
	Sta Registr		VON	04 2004	20	Safte from the con	19	Loan	Kal	/							

		•	For State Registrar	State of	of Marylan		artment o			nd Me		giene 0) 4	36764
	Physicia		1. Decedent's Name (First, Mic Elnora Collin								2. Date of Dea Month	Day	Year 2004	3. Time of Death
	/Medic Examin		4a. Facility Name (If not institut	ion, give street and nu	Ave n	cu	4b. City, Tow	n, or Loo				4c. Gount	of Death	evers
	Funeral Director		5. Social Security Number 240–02–1534	6. Sex 1 □ M 2 □XF	7. Age (In yrs. I	last birthday) Yrs.	If Under 1 You Months Da		Under 24 lours	4 Hrs. Min.	8. Date of Birtl (Month, Day Sept 16	, 1906	Çgun	lace (State or Foreign try). ginia
	Aaryland f show ed at	or	Usual Residence of Decedent 10a. State 10b. Cour MD Prin	nty ce George's	1	y, Town or Lo Brandyw							10	0d. Inside City Limits 1 X Yes 2 No
	with the N a or 28a- be notifi	Direct	10e. Street and Number				10f. Zip Cod					10g. Citizen of		try?
36	s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mentle Hygiene. If Health and Mentle Hygiene. It mentle a file than 7 inatural, or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	by Funeral Director	12507 Lytton A 11. Marital Status 1 Never Married 2 M 3 Widowed 4 Divorce	12. Was Dec Armed F arried 1 1 7 cs	2[X]No ive		206 Was Decedent f Yes, specify (of Hispai Cuban, M	nic Origi Mexican, Specify:	n? (Spec Puerto P	cify Yes or No- lican, etc.)	U.S.A 14. Rad Bla Specif	ce - America ck, White, e	etc.
21215-0036	filed within 72 hou Hygiene. Ither than "nature Int, the Medical E	Completed		ent's Education hest grade completed)	1-4or 5+)	(Give life. I	dent's Usual Ockind of work do 00 NOT use re nemaker	ccupation one durin etired)	n ng most d	of workin	g	16b. Kind of B		dustry
Maryland	should be file ind Mental Hy is marked othe umatic evant,	To Be C	17. Father's Name (First, Middle Thomas Champie					18.	Mother's Alic		(First, Middle,	Maiden Sumar Chan	pion	
	s 1 and 2 sho of Health and I item 27 is me other traume		19a. Informant's Name/Relatio James E. Coll 20a. Method of Disposition		20b. P	2130 lace of Dispo		Dr. A			restvill	r, City or Town, e Ml. 207 20c. Location	747	
Baltimore,	permit. Pages Department of I Important: If its any injury or o		1 ABurial 2 Crematio 4 Donavion 5 Other 21. Signature of Fun ral Servio	(Specify)		rchett (hapel Co	m. ddress of	f Facility			Manson, Fisher Fl		Home
Ī	Physician		23a. Part1. Enter the disease, shock, or heart failure. Limmediate Cause (Final	ist only one cause on	caused the death each line.		er the mode of	dying, su	uch as ca	ardiac or	respiratory arr	rest,	7 0 -0	Approximate Interval Between Onset and Death
	/Medical Examiner		disease or condition resulting in death)	Due to	(or as a consequ		74							
,09	s be executed sicien and burial-transit	Ical Examiner	Sequentially list conditions, and the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	6	(or as a consequ									
O. Box 68760	death certificate e attending phy d for use as the	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 Live	itcome of pregnal birth 2 Tetal nant at time of de lown	death 3	Ectopic pregna Other (specify						te of deliver	ry Day Year
ds, P.O.	uires that the signed by the signed by the detaction of the detaction of the signed by	by	Part II. Other significant cond	itions contributing to c	leath but not resu	ulting in the u	nderlying cause	given in	Part I.			bacco use cont	ribute to the	e cause of death?
I Records,	The law requires that the ate has been signed by the page 2 should be detached.	Completed								_	24a. Was a autop: perfor 1 Yes	med?	prior to con death?	osy findings available apletion of cause of
Vital	Physician: Th this certificate ral director, pa	To Be (25. Was case referred to medi examiner? 1 ☐ Yes 2 ☐ No	Hospital	Inpatient 2 1	ER/Outpatien	t 3 DOA	Other			(Check only or	ence 6 □Oth	er (Specify)
ion of	D 00 00		27. Manner of Death 1 Natural 5 Pen 2 Accident	ding 28a. Date (Monstigation	of Injury oth, Day Year)	28b. Time of Injury		Injury at Work? 1 Yes		28		ow injury occur		
Division	i Dir	Certification;	3 ☐ Suicide 6 ☐ Cou 4 ☐ Homicide dete	mined 286. Place	e of Injury - At ho ing, etc. <i>(Specify</i>	ome, farm, str	eet, factory, off	ice		28	3f. Location (S City or Town		er or Rural	Route Number,
	To tha Hospital within 24 hours a To tha Funeral Completely filled	Medical ((Check only 2 Medic one)				restigation, in n	ny opinio	n, death		d at the time, d	late and place,	and due to	the cause(s)
	To tha within 2 To tha comple	2	29b. Signature and title of certi	oder B	heter,	00		ense nui		92		Pod. Date signe		
K	(2)		30. Name and address of persons	/usTer,	3001.	Hospi	Print) I	Prèn	e (fre	verla	Nest.	rglan	5,2004
No.	Sta Registr		31. Date filed (Month, Day, Ye. NOV 0 8	2004 2. F	Registrar's Signat	ture	e				./			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Month Colburn November 3, 2004 /Medical Evelyn 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Ring House Rockville Montgomery If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 9. Birthplace (State or Foreign Country) New York 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 1 □ M 2 🖾 F 88 124-03-2876 April 26,1916 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits X☐Yes 2 ☐ No Director Rockville Maryland | Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20851 U.S.A. 1801 E. Jefferson St. Funerai 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No Specify: ģ 3X Widowed 4 □ Divorced white Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) U.S. Government Statistician 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Unobtainable Jane Witt 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7504 Elmore Ln. Bethesda, MD 20817 Kenneth Colburn/son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition
1 ♣ Burial 2 □ Cremation 3 □ Removal from State 20c. Location - City or Town, State 4 □ Donation 5 □ Other (Specify) King David Cemetery 11/7/2004 Falls Church, VA 21. Signature, of Funeral Service Licensee 22. Name and Address of Facility Hines-Rinaldi F.H. 11800 New Hampshire Ave. Silver Spring, MD 20904 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Congestive Heart Failure disease or condition resulting in death) Due to (or as a consequence of): Chronic Obstructive Pulmonary Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dualty for as a goneaduenea offi Examine Coronary Artery Disease Due to (or as a consequence of): Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? Year 5 Other (specify) 4☐Pregnant at time of death Yes 9 Unknown 9 🗀 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 XNo 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 1□ Yes 💥 No 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 XX ther (Specify) Living 1 ☐ Yes XXNo Hospital: ² 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 🗀 Accident 3 ☐ Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[I] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) M. Cameron and 1556 11 14 SROW MY 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Van W ennsc Kawer 2100

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

NOV 0 5 2004

Funeral

Director

?7 is marked other than "natural", or items 23a or 28e-f show traumetic event, the Medical Examiner man be matified at

permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than "any injury or other traumetic event, the Me once.

Pnysician

/Medical

Examiner

attending physician and for use as the burial-transit

detached

The law requires that the death certificate be executed

Hospital or Attending Physician:

To tha

this

within 24 hours after death, To the Funeral Director: A completely filled in by the fu

6

filled in by

Division of Vital Records, P.O. Box 68760,

the Maryland

death with

filed within 72 hours after

Baltimore, Maryland 21215-0036

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend item 14, 18 per inf 838 12-3-04 yt.

State of Maryland Edepartment of Health and Mental Hygiene 2 0 0 1 For State Registrar 004 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Oct. 31°, 2004 11:10PM CROOKS RIIRV Μ. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Village Montgomery Montgomery Village Nursing If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year)
May 25,1937 7. Age (In yrs. last birthday) 6. Sex Birthplace (State or Foreign Country) **Funeral** 1 M X F 67 Director 578**-**68-7527 N. Carolina Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 23a or 28e-f show 10d. Inside City Limits the Medical Examinar must be notified at Rockville Director MD Montgomery 1X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9800 Gable Ridge Ter. 20850 U.S.A. death Funeral 14. Race - American India Amer. "neturel", or Items 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. Indian within 72 hours after 1 □Yes 2√ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 🕦 No Specify þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Importent: If item 27 Is marked other than." Elementary/Secondary (0-12) College (1-4or 5+) 8th Electronic Supervisor Case Comm 18. Mother's Name (First, Middle, Maiden Sumame) **Eula Mae Locklear** 17. Father's Name (First, Middle, Last) Be Huey Locklear 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James W. Crooks (Husband) 9800 Gable Ridge Ter, #I, Rockville, other t 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 5 Harmony Mem. Park 11/8/04 Landover, MD J Foreral Service Licenses 21. Synatur 22. Name and Address of Facility Snowden Funeral Home, P.A any -246 N. Washington St Rockville, MD20850 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** End State Hepatocellullar Carcinoma /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed physician and s the burial-transit Due to (or as a consequence of): Completed by Physician/Medical as pulpu IF FEMALE use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant atten for us 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown 9 Unknown signed to Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Hunknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed? certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes To the Hospital or Attending Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death Check onl one Hospital: 1 ☐ Inpatient Other: 2 1 ☐ Yes 🏖 Xio 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) After thi funeral 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death Certification: 28d. Describe how injury occurred 5 Pending investigation 1X Natural death. 1 ☐ Yes 2 ☐ No 2 Accident I Director: d in by the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide hours after within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760.

19520 Dorcors

32. Registrar's Signature

30. Name and a dress of person who completed cause of death (Item 23a) (Type, Print)

M.D.

Vinu Ganti

31. Date filed (Month, Day, Year)
NOV 0 5 2004

D41162

Drive, Germantown, MD 20874

11/2/04

	1 - For State of Maryland / Department of Certificate of	f Dooth	giene Reg. No. 2001 3676:
Physician /Medical		2. Date of Dea Month	ath Day Year 3. Time of Death
Examiner	4a. Facility Name (If not institution, give street and number) St. Catherine's Nursing Center 4b. City, Town Emmits!		4c. County of Death Frederick County
Funeral Director	5. Social Security Number 395-07-4395 6. Sex 1 Months Day 86 Yrs. 1 Months Day		9. Birthplace (State or Foreign Country) 1918 Wisconsin
Maryland -f show	Usuat Residence of Decedent 10a. State 10b. County 10c. City, Town or Location Maryland Frederick County Emmitsburg		10d. Inside City Limits 1 🛣 Yes 2 🗆 No
n with the Mar 3a or 28a-f st at be notified		4.70.7	10g. Citizen of What Country? United States
Ind Z1Z13-UU35b be filed within 72 hours after death with the Maryland tal Hyglene. Id other then "naturel", or Itams 23a or 28a-f show event, the Medical Eventire must be notified at Be Completed by Funeral Director	If Yes, Give 1 ☐ Yes 2⁴ N 3 ☑ Widowed 4 ☐ Divorced Year or Dates:	of Hispanic Origin? (Specify Yes or No- uban, Mexican, Puerto Rican, etc.) No Specify:	14. Race - American Indian, Black, White, etc. Specify: White
Maryland 21215-0035 d 2 should be filed within 72 hours att tht and Mental Hyglene. 27 ie markad other then "naturel", or traumatic event, the Medical Event To Be Completed by F	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0·12) College (1·4or 5+) 5+ 16a. Decedent's Usual Occ (Give kind of work dor life. DO NOT use refi	cupation ne during most of working ired)	16b. Kind of Business/Industry nursing
	17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Mary M. (maid	Maiden Sumame) len name unknown)
		eet and Number or Rural Route Number est Drive Clarks	r, City or Town, State, Zip Code) Sburg, Maryland 20871
Page nent o ent: If ury or	20a. Method of Disposition 1	torium Nov. 15	20c. Location - City or Town, State Smithsburg, Maryland
permit. Deporte Importe any inji	21. Signature of Funeral Service Licenses 22. Name and Add 210 West	dress of Facility Skiles Fun	eral Home nitsburg, MD 21727
cate be executed // Medical Examiner the burial-transit dical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of d shock, or heart failure. List only one cause neach line. Immediate Cause (Finat disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or rinjury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):	ction Jacula Di	Interval Batween Onset and Death
that the death certificate be executed ned by the attending physician and detached for use as the burial-transity Physician/Medical Examir	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 X No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnant at time of death 5 Other (specify)		23d. Date of delivery Month Day Year
es that igned b be deta by Pł	The state of the s	given in Part I. 23e. Did tot	bacco use contribute to the cause of death? es 2 No 3 Probably 4 Unknown
The law ate has b page 2 si	25. Was case referred to medical	24a. Was an autops perform 1 Yes 2	prior to completion of cause of death?
ding Phys After this funeral di	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be 28a. Date of Injury (Month, Day Year) 28b. Time of Injury W	Other: 4 Nursing Home 5 Reside Reside Reside Reside Reside	ance 6 ☐Other (Specify) ow initury occurred
in Signal	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 29a. Certifier 1 X Certifying Physicien: To the best of my knowledge, death occurred at the	City or Town	·
To the Hospital or Attenwithin 24 hours after deall within 24 hours after deall To the Funerel Director: completely filled in by the Medical Certifical	one) and manner stated.	y opinion, death occurred at the time, da	ause(s) and manner as stated. ate and place, and due to the cause(s) 9d. Date signed (Month, Day, Year)
ı	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Alan L. Carroll, M.D. 310 South Seton Ave)/() /U)	Maryland 21727
State Registrar	31. Date filed (Month, Day, Year) NOV 1 9 2004 Second Average Aparts Signature	muit capaty,	maryrana 21/2/

Amend item#25, per HE, G837, 11/1/04 Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** June 8:40 P CONTEE JR. CALVIN . /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Southern Maryland Hospital Clinton Prince George's 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 8. Date of Birth (Month, Day, 12 7 **Funeral** Days 1**☑** M 2□ F Months Hours Min. Yrs. Director 31 12 Washington, DC 577-94-6368 Usual Residence of Decedent 10a State 10c. City, Town or Location 10b County 10d. Inside City Limits item 27 is marked other then "natural", or itams 23a or 28a-f ahow other traumatic event, the Martical Exercities at Director MD Prince George's Temple Hill 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2754 Iverson Street 20748 U.S.A. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☑ Married Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Black. Specify 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12th Chef Private 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, 1 and 2 should be fill Health and Mental H tem 27 Is markad oth Be Calvin Contee ္ပ Elizabeth Stewart 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If Item 27 Is any injury or other tra 2754 Iverson Street Temple Hill, Maryland 20748 Contee/Wife Angela 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Harmony Cemetery ¹ 4 □ Donation 5 □ Other (Specify) 6/17/2004 Landover, Maryland 22. Name and Address of Facility J. B. Jenkins Funeral Home 21. Signature of Funeral Service Licensee 7474 Landover Road Landover, Maryland 20785 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failule. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Brain **Physician** stem Hemor 5 day disease or condition resulting in death) /Medical Examiner Hypera Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury CERTIFICATION APPROVED BY MEDICAL EX Due to (or as a consequence of) Examiner The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760. attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 5 Other (specify) the 9 Unknown 9 Unknown signed by Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown director, page 2 should Be Completed certificate has been 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 1 ☐ Yes 21 No 1 ☐ Yes 2 ☑ No 25. Was case referred to medical 26. Place of Death Check onl one examiner' Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 X Yes 2 Certification: To this funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After Hospital or Attanding 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation Director; 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours at To the Funeral D 29a. Certifier 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 046478 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Suresh Sumatts Rd. Clinton. mp 20735 Patelino A. 31. Date filed (Month, Day, Year)
JUN 1 5 2004 2. Registrar's Signature State Registrar

			4 For	State of Man	yland / Depa	artment of I	Health and	Mental Hyg		_
			1 - State Registrar		Cei	tificate of	Death		eg. NZ 0 0 4	
	Physici		Decedent's Name (First, Middle, Last, Mary Rebecca Crou					2. Date of Deat Month	Day Yea	
	/Medic		4a. Facility Name (If not institution, give			4h City Town	or Location of Dea	Nov	1 200 4c. County of De	
	Examin	ier	21850 Water Stree			Presto		uı	Carolin	
	Funeral		Social Security Number 6. Sec.	7. Age (li	n yrs. last birthday)	If Under 1 Year	If Under 24 Hrs	8. Date of Birth	9.5	le Sirthplace (State or Foreign Country)
5.	Director		220-40-3740]M 2XIF	93 Yrs.	Months Days	Hours Min	July 27	1911 Ma	ryland
	and		Usuel Residence of Decedent 10a. State 10b. County	10	Oc. City, Town or Lo	cation				10d. Inside City Limits
	Manyl f sho	ţō	Maryland Carolin		Preston					1 ☐ Yes 2 No
	r 28a	Director	10e. Street and Number		Treston	10f. Zip Code	* ₉₁	10	0g. Citizen of What (Country?
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Iteme 23a or 28a-f show any injury or other traumatic event, The Medical Examination intelligible and ONEs.		21850 Water Street			21	655		USA	ŕ
	leme leme	Funerai	11. Marital Status	12. Was Decedent Eve Armed Forces?	r in U.S. 13. \	Was Decedent of H	dispanic Origin? (S	Specify Yes or No- to Rican, etc.)	14. Race - Ar Black, Wh	nerican Indian,
36	s afte	by Fu	1 ☐ Never Married 2 ☐ Married 3 🛣 Widowed 4 ☐ Divorced	1 ☐ Yes 2 No	1	I ☐ Yes 2√2 No		,,	Specify:	White
21215-0036	thous	ed t	15. Decedent's Edu	Year or Dates:	16a, Decer	lent's Usual Occup	nation		16b. Kind of Busines	
215	nn na	Completed	(Specify only highest grade Elementary/Secondary (0-12)		(Give	kind of work done OO NOT use retire	during most of wo d)	rking	IDD. NING OF BUSINES	sylnaustry
21	d with	Com	10	College (1-401 3+)	Но	memaker			Own home	
pu	be file tal Hy d oth	Be	17. Father's Name (First, Middle, Last)				18. Mother's Ne	me (First, Middle, M	faiden Sumame)	
yla	ould Men	P	David Baynard					tranahan 1		
Maryland	12 sh h and 7 Is m traum		19a. Informant's Name/Relationship (Ty	-					City or Town, State,	
e,	1 and Healt em 2 ither		Gloria Trice/ daug 20a. Method of Disposition			O Water S			Maryland 2	
nor	ages ant of tt: If It		1 X Burial 2 □ Cremation 3 □ R *4 □ Donation 5 □ Other (Specify)	OHIOVALI HOHI OLALO	20b. Place of Disposementery, crem				_	
Baltimore,	artme ortan injur		21. Signature of Funeral Service License		Greensbor			5 2004 Show 160	Greensbor	o, Maryland
Ba	Depa Impo Any i		1016	un	F16	eegle and	d Helfent	o box 160 Se i n Fune:	Greenbord cal Home,	, MD 21639
£	**************************************		23a. Part1. Enter the disease, or compli shock, or heart failure. List only or	cations that caused the						Approximate Interval Between
	Pnysician /Medical		Immediate Cause (Final disease or condition resulting in death)	BILL	ARY T	RACT	CA	LCIND	MA	Onset and Death
	Examiner			Due to (or as a co	nsequence of);					
æ	Short	ler	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a co	insequence of):					
	cuted	Examiner	Cause (Disease or injury that initiated events							
oʻ	ate be executed hysician and the burial-transit	Exa	resulting in death) Last	Due to (or as a co	nsequence of):					
8760,	ate be hysici the bu	lical								
89 x	The law requires that the death certificat te has been signed by the attending phy bage 2 should be detached for use as the	Physician/Med	IF FEMALE:							
Вох	attend for us	ian/	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of p	Fetal death 3	Ectopic pregnancy	,		23d. Date of de Month	elivery Day Year
o.	it the death by the atte tached for	ysic	1 Yes 2 No	4☐ Pregnant at time 9☐ Unknown	ofdeath 5∐	Other (specify)				Day Tour
Δ.	res that th igned by be detacl	y Ph	Part II. Other significant conditions con	tributing to death but no	ot resulting in the un	derlying cause give	en in Part I.	23e. Did toba	acco use contribute t	to the cause of death?
rds,	quires n sign	ed by	HYPERTE	NSTON				1 ☐ Yes	2 € No 3 □ P	robably 4 Unknown
CO	law requir as been s 2 should	Completed	DEABET	ES ME	LLET	71 5		24a. Was an	24b. Were a	utopsy findings available
Re	The lay	mo	2.700		1000	<u> </u>		autopsy perform	prior to death?	completion of cause of
Vital Record		BeC	25. Was case referred to medical				26. Place of Dea	1 ☐ Yes 2 (ath (Check only one)		s 24 No
ot <	Shysic this ce al direc	To	examiner? 1 ☐ Yes 2 No H	ospital:	2 ER/Outpatient	3□ DOA Oth	0.50		ice 6 Other (Spe	ecify)
ב	ding Ph h. After th funeral		27. Manner of Death 1 ■Natural 5 □ Pending	28a. Date of Injury (Month, Day Yea	28b. Time of Injury	28c. Injun Worl		28d. Describe how		
Division	tendi jeath. tor: A the fu	Certification:	2 Accident investigation 3 Suicide 6 Could not be				Yes 2 □No			
<u>></u>	I or Attendate death Director:	in in	4 Homicide determined	28e. Place of Injury - building, etc. (S	At home, farm, stre pecify)	et, factory, office		28f. Location (Stre City or Town,	et and Number or R State)	ural Route Number,
_	Mospitel 24 hours a Funerel I		29a. Certifier 1 Certifying Phys	ician: To the best of my	knowledge death	occurred at the time	no, data and alace	and due to the cou	(a-1-)	
	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certifics completely filled in by the funeral director.	Medical	(Check only 2 Medical Examination)	er: On the basis of exa and manner stated.	mination and/or invi	estigation, in my of	pinion, death occu	rred at the time, dat	e and place, and du	s stated. e to the cause(s)
	To the To the Complet	W	29b. Signature and title of certifier			29c. License	e number	290	d. Date signed (Mon	th, Day, Year)
			2 mich	10 hue	K M.)	73	504	3	11/03	104
			30. Name and address of person who con	npleted cause of death	(Item 23a) (Typa, P	Print) n ₂ ~	11 0	1 1	DI C.	1 - 11 2
			31. Date filed (Month, Day, Year)	32. Registrar's S	e IVIL) &S	4 Cer	11/5/11	c Kd LC	ntrey, Helph
254	Stat Registra		MOV 5 20	O.A. Hegistrar's S	oignature	2000				

			- FOI	partment of Health and Mertificate of Death		ene g. No.2004	36770
	4		Decedent's Name (First, Middle, Last)		2. Date of Death		3. Time of Death
	Physicia /Medic		Samuel John Carnicelli		November	4, 2004	5:45 A M
	Examin		4a. Fecility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Deeth	
			910 Decesaris Drive	Lothian		Anne Arund	
	Funeral		5. Social Security Number 6. Sex $\begin{array}{cccccccccccccccccccccccccccccccccccc$	y) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Dey,) March 7.	Yeer) 9. Birthol County 1943 New	ece (State or Foreign try)
	Director	-	Usual Residence of Decedent		waren 7,	T949 New	York
	show		10a. State 10b. County 10c. City, Town or	Location		10	Od. Inside City Limits
	e Ma	Director	MD Anne Arundel Co. Lothia	1			1 ☐ Yes 2X No
	or 24	Pre	10e. Street and Number	10f. Zip Code	109	g. Citizen of What Coun	try?
	3ath v	era	910 Decesaris Drive	20711 3. Was Decedent of Hispanic Origin? (Spe	ecify Yes or No.	U.S.A.	an Indian
10	r Item	Funeral	Armed Forces? 1 ☑ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No	If Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	Black, White, e	
21215-0036	be filed within 72 hours after death with the Maryland that Hyglene. do other than "natural", or iteme 23e or 28e-f show event, the Madical Examinal results institlied at	by	3 ☐ Widowed 4 ☐ Divorced Year or Dates:	1 ☐ Yes 2 ☒ No Specify:		Specify: Whi	te
5-0	72 hc 'natur	Completed	(Specify only highest grade completed) (G.	cedent's Usual Occupation ve kind of work done during most of work	ing 16	6b. Kind of Business/Ind	lustry
121	within noe. than	du	Elementary/Secondary (0-12) College (1-4or 5+)	DO NOT use retired)	,		
CA	filed Wygie		12 17. Father's Name (First, Middle, Last)	Book Keeper 18. Mother's Name	e (First, Middle, Ma	Transportat aiden Sumame)	ion Co.
Maryland	S should be filed within and Mental Hygiene. Is marked other than aumatic event, the Mannatic event.	To Be	John Carnicelli	Viola G	ermano		
ary	should and Men marke umatic	-	19a. Informant's Name/Relationship (Type, Print) 19b. Ma	tiling Address (Street and Number or Rura			
	is 1 and 2 should of Health and Men item 27 le marke other traumatic			Decesaris Drive, L			
Baltimore,	Pages 1 and intention of Health int: If Item 27 iry or other tr	١.,	20a. Method of Disposition 20b. Place of Disposition 1 □ Burial 2 ☑ Cremation 3 □ Removal from State	position (Name of rematory or other place)	ber 4,	Oc. Location - City or To	wn, Stete
ţ	trent tant: h		'4 □Donation 5 □ Other (Specify) Lee Cr	ematory 200	The same of the sa	Clinton, M	
Bal	permit. Pages Department of Important: If I eny injury or once.		21. Signature of Funda 36 vo. Lettenson	22. Name and Address of Facility Lee 8125 Southern Maryl			•
5.			23a Pert1, Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line.	enter the mode of dying, such as cardiac of	or respiratory arres	st,	Approximate Interval Between Onset and Death
個	Physician		Immediate Cause (Final disease or condition resulting in death)	ocardial interve	tion		Onset and Death
	/Medical Examiner		Due to or as a consequence of):	1 1 1 1			
N		ē	Sequentially list conditions, fany, leading to immediate b. Due to (cr as a consequence of):	Thesal Masse	_		
	d d ansit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events				
0,	The law requires that the death certificate be executed to be a seconted at a been signed by the attending physician and bage 2 should be detached for use as the burial-transit		resulting in death) Last Due to (or as a consequence of):				,4
8760,	ate be shysical the bu	dical	d				* *
9	eath certific attending p	/Mec	IF FEMALE: 23c. If yes, outcome of pregnancy			22d Date of delice	**
Вох	atten for us	Physician/Me	in the past 12 months?	3 □Ectopic pregnancy 5 □ Other (specify)		23d. Date of deliver Month	Day Year
P.O.	that the de ted by the a detached	hysl	1 Yes 2 No 9 Unknown 9 Unknown				
	ires that signed t d be det	by P	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did toba	acco use contribute to the	
ord	w require been signshould t	ted 1	MoRloid Obesity		1 🗆 Yes	2 No 3 Proba	ably 4 Uaknown
of Vital Records,	e law r has be je 2 sh	Completed	1		24a. Was an autopsy	prior to con	sy findings available appletion of cause of
E E		S			performe 1 □ Yes 2	ed? death?	2 No
Vita	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner Hospital:	Other	h (Check only one)		
	문 등 편	7: To	27. Mann of Death 28a. Date of Injury 28b. Time	of 28c. Injury at	me 5 Hesiden 28d. Describe how	nce 6 Other (Specify v injury occurred)
on	nding Phy th. : After thi s funeral	tlor	1 Natural 5 ☐ Pending (Month, Day Year) Injur 2 ☐ Accident Investigation	y Work? M 1 ☐ Yes 2 ☐ No			
Division	I or Attendi after death, Director: A I in by the fo	Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office	28f. Location (Stre City or Town,	et and Number or Rural State)	Route Number,
	ital ours aft						
	To the Hospital or Attending within 24 hours after death, To the Funaral Director: Attercompletely filled in by the fune	edical	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, do not not not not not not not not not no				
	To the within 2 To the complet	Σ	29b Signatore and title of certifier	29c. License number	290	d. Date signed (Month, L	Day, Year)
			tap (a) toll	1017324		November 4	2004
	10		30. Name and address of person who completed cause of death (item 23a) (Tyr		3 0000	2	
	Sta	ite	Raymon A. Noble, M.D. 32 Cox Road, 31. Date filed (Month, Day, Year) NOV 0 5 2004	Huntingtown, Maryl	and 20639	9	
	Registi	_	NOV 0 5 2004 Server L	Aparle .			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 🤈 04 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Month Year Robert Warren Cheseldine 2004 5:00 a^M October 31 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Heartland Health Care Center-Adelphi Adelphi
If Under 1 Year If Under 24 Hrs. Prince Georges 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral Days 1**∑**M 2□F Hours Director 579-84-1464 May 5, 1929 Wash., D.C. Usual Residence of Decedent death with tha Maryland 10a. State 10b. County 10c. City, Town or Location 28a-f show 10d. Inside City Limits ust be nutitied at Directo 1 ☐ Yes 2 No MDPrince Georges Adelphi 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or Itams 23a 1801 Metzerott Road 20783 Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. Int: If item 27 is marked other then "naturel", or Ital 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: þ Specify: 3 ☐ Widowed 4 ☐ Divorced white Completed traumatic avant, If a Madical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 0 none never employed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Cheseldine Robert 2 Boyd Lillian Marie 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If itam 27 is any injury or othar trai <u>once</u>. Margaret L. Lacey, 614 California Ave., Rose Haven, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Cedar Hill Cemetery | 11-04-2004 Suitland, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility William Rausch Funeral Home, P.A., Owings, MD 20736 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician disease or condition resulting in death) Cardiovascular Disease vears /Medical Due to (or as a consequence of): **Examiner** Hypertension Sequentially list conditions, if any, leading to immediate cause. Enter the corting Cause (Disease or injury that initiated events resulting in death) Last years Due to (or as a consequence of): Examine The law requires that the death certificate be executed Due to (or as a consequence of): attending physician a for use as the burial-Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Dav Year 4 Pregnant at time of death 5 Other (specify) the ģ signad t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ mental retardation, profound 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? pulmonary nodule 24a. Was an autopsy performed? page 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 XNo Physician: director, 25. Was case referred to medical examiner? 26. Place of Death Check on one 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٩ 1 ☐ Yes 2X No this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred After Hospital or Attanding 1 Natural 2 Accident 5 Pending death. 1 ☐ Yes 2 ☐ No investigation after death Diractor: 6 Could not be determined 3 T Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral L t Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai (Check only one) 29b. Signature and 29c. License number 29d. Date signed (Month, Day, Year)

P.O.

of Vital

Division

State Registrar

Stuart J.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Turkewitz, M.D.

NOV 0 4 2004 >

D 31001

M.D. 7500 Greenway Ctr. Dr., # 430, Greenbelt MD 20770

10-31-2004

			For State	State of Maryla		rtment of Hea		tal Hygiei	ne	
			Registrar 1. Decedent's Name (First, Middle, Last)		L	uncate of De	2.0	Reg.	2004	3. 10 o 1 Dati2
	Physici /Medic		THoma	s Da	nde	5		Month I	Day Year 2009	10100 M
	Examir		4a. Facility Name (If not institution, give	street and number)	110	4b. City, Town, or Log	cation of Death		4c. County of Death	n'a n
100	Funeral		5. Social Security Number , 6. Se		last birthday)		Under 24 H/s. 8. D	ate of Birth	Wicar 9. Birth	
	Director		010 70 1001	M 2□F 7	7 / Yrs.	Months Days H	lours Min. (/	Month, Day, Yei	1933 Ne	place (State or Foreign intry) W Jersey
	land ow		Usual Residence of Decedent 10a. State 10b. County	10c. C	ity, Town or Loc	ation				10d. Inside City Limits
	a-f sh	ctor	Maryland Wicomic	20 8	Salisbu	ry				Y⊟Yes 2 No
	th with the 23a or 28	al Director	351 Deer's Head Ho	spital Rd.		10f. Zip Code 21802		10g.	Citizen of What Cou USA	intry?
920	be filed within 72 hours after death with the Maryland ital Hygiene. id other than "natural", or items 23e or 28e-f show event, the Medical Exam are must be inclined at	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☑ Yes 2 □ NNAV If Yes, Give Year or Dates:	y If	Vas Decedent of Hispar Yes, specify Cuban, M ☐ Yes 2 No Sp	nic Origin? (Specify Mexican, Puerto Ricar pecify:	Yes or No- n, etc.)	14. Race - Amer Black, White Specify:	
15-0	"natu	letec	15. Decedent's Edu (Specify only highest grad		(Give k	ent's Usual Occupation	n ng most of working	16b.	Kind of Business/Ir	ndustry
7121	e filed within at Hygiene. other than "	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		ONOT use retired) Coperator		Us	ed Car Bu	siness
Maryland 21215-0036	ild be filed lental Hygie ked other ic event, I	To Be C	17. Father's Name (First, Middle, Last) Thomas Frank Danc	les		18.	Mother's Name (Firs	st, Middle, Maid O'Shea	en Sumame)	
	ges 1 and 2 should be t of Health and Mental if item 27 is marked or or other traumatic ev		19a. Informant's Name/Relationship (Ty Debra M. McCleary			Address (Street and I				p Code)
Baltimore,	of Hea of Hea if item or othe		20a. Method of Disposition 1 Burial 2 Cremation 3 F	20b.	Place of Dispos cemetery, crem	ition (Name of atory or other place)	Date	20c.	Location - City or T	own, State
ţi	Pa June Pa		`4 ☐ Donation 5 ☐ Other (Specify)	Sa.		Crematory	11/4/04		lisbury,	
Bal	permit. Departr Importa any inji		21. Signature of Euneral Pervice License	y CFSP))	OTIOWAY FU OI Snow Hi	II Rd.,Sa.	Lisbury	ssional A MD 21804	ssociation
6			23a. Part1. Enter the disease, or combi- shock, or heart failure. List only or Immediate Cause (Final	ications that caused the dea ne cause on each line.	th. Do not ente	r the mode of dying, su	ich as cardiac or resp	oiratory arrest,		Approximate Interval Between Onset and Death
	Pnysician /Medical		disease or condition resulting in death)	Due to (or as a consec	TILL C	m (6	nec			Zyrs
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	pe țist	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter under injury that injury that injury that injury that injury the conditions to the c	Due to (or as a consec	quence of):					
,	execut n and ial-trar	Exan	that initiated events resulting in death) Last	Due to (or as a consec	quence of):					
8760,	cate be executed physician and The burial-transit	dical		J						
x 68	ertifica ling ph	Med	IF FEMALE:							
.O. Box	that the death certificate by the attending a detached for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	3c. If yes, outcome of pregn 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of o 9 ☐ Unknown	aldeath 3 ⊟6	Ectopic pregnancy Other (specify)			23d. Date of delive Month	ery Day Year
Vital Records, P.	se es	by	Part II. Other significant conditions cor	ntributing to death but not res	sulting in the und	derlying cause given in	Part I. 2	~	use contribute to to	he cause of death?
9C0	e law requir has been si je 2 should	ompleted					2	4a. Was an	24b. Were auto	psy findings available
<u> </u>	The ate h page	Com					1	autopsy pedormed? Yes	death?	mpletion of cause of
Vita	Physician: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?	lospital:		Other	Place of Death (Che	, , , , , ,		
ŏ	g Phys er this eral di	n: To	27. Manner of eath	28a. ate of Injury	ER/Outpatient 28b. Time of	3 DOA Other: 4 28c. Injury at Work?	□ Nursing Home 5	Residence Describe how inj		(y)
sion	Attending r death. ector: After by the fune	atlo	Natural 5 Pending investigation	(Month, Day Year)	Injury	M 1 ☐ Yes	2 🗆 No			
Division of	or Atte	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At h building, etc. (Specia	ome, farm, stree	et, factory, office	28f. Lc	ocation (Street a lity or Town, Sta	and Number or Rura te)	I Route Number,
	spitel		29a. Certifier Certifying Phys	sician: To the best of my kno	owledge, death	occurred at the time, da	ate and place, and di	ue to the cause/	s) and manner as s	ated
	To the Hospitel or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	Medical	(Check only 2 Medical Examination)	ner: On the basis of examina and manner stated.	ation and/or inve	stigation, in my opinior	n, death occurred at t	the time, date a	nd place, and due to	the cause(s)
	To t Com	Σ	29h Bignature and title of certifier		1.0	29c. License num	nber	29d. D	ate signed (Month,	
Ŧ	7		20 Name and address of a second	molecular and a series of the	W)	W 6	218	Į.	11-4-	- 0 /
1	8		30. Name and address of person who co	P.O. B	× 17	77	lish,	MD	11-4-	2
ir	Sta Registr		NOV 0 4 2	32. Registrar's Signa	ature &	Sporks	, 0'			

			1 - For State Registrar	State of Maryland /	Depa Cer	artment of H tificate of L	lealth ar D <i>eath</i>	nd Mental H	ygiene2	04	36773
П	э Physici	an	1. Decedent's Name (First, Middle, Last)					2. Date of D	Death Day	Year	3. Time of Death
	/Media		Clamore	Dankmeyer				Novem	ber 7, 2	2004	12:00 P.M
	Examir	er	4a. Facility Name (If not institution, give st			4b. City, Town, or		Death	4c. Count	ty of Death	1
	Formul		Glade Valley Nurs: 5. Social Security Number 6. Sex	7. Age (In yrs. last t	hirthday)	Walkersv	If Under 24	Hrs. 8 Date of B		deric	
	Funeral Director			M 2□ F 73	Yrs.	Months Days		Min. (Month, L	2, 1931	Mary	place (State or Foreign http:/ Land
	pur ,		Usual Residence of Decedent 10a. State 10b. County	10c. City, To	um or lo	oction					
	Maryla f sho	0	Maryland Frederick								10d. Inside City Limits 1 X Yes 2 ☐ No
	28a-	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of	What Cour	
	th with	alD	1421 Taney Avenue	Apt.320		21702			United S		,
980	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other then "naturel", or Items 23e or 28e-f show enty injury or other treumatic event, I'm Medical Exer'il art must be rediffied at once.	by Funeral	11. Marital Status 1: 1 Never Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent Ever in U.S. Armed Forces? 1		Vas Decedent of Hi Yes, specify Cubal ☐ Yes 2 X No	spanic Origir n, Mexican, I Specify:	n? (Specify Yes or N Puerto Rican, etc.)	lo- 14. Ra Bla Speci	ce - Americack, White,	etc.
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Maryland 21215-0036	ould be f Mental } warked o	To Be	Clamore Dankmeyer				Kathe		pes		
Ma	d 2 sh th and 7 is n treun		19a. Informant's Name/Relationship (Typ Virginia Dankmeyer		9b. Mailin 421	g Address <i>(Street a</i> Canev Ave	Ant.	320, Fred	ber, City or Town	State, Zip	702
ē,	1 an Heal tem 2 other		20a. Method of Disposition	20b. Place	of Dispos	sition (Name of		Date	20c. Location		
timore,	Pages ent of nt: If i		1 ☐ Burial 2 ☑ Cremation 3 ☐ Re 1 ☐ Donation 5 ☐ Other (Specify)	movariiom state		cremator		/09/2004		•	Maryland
Balti	permit. Departm Importa eny inju		21. Signature of Funeral Service Vicensee		22.	Name and Addres	s of Facility	Stauffer I Pike,Free	Funeral	Home,	P.A.
	_		23a. Part1. Enter the disease, or complic shock, or heart failure. List only one	ations that caused the death. Do		-					Approximate
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		iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause C. Issues of injury.	Due to (or as a consequence	e of):					_	-
8760,	cate be executed chysician and the burial-transit	dical Examiner	that initiated events resulting in death) Last c.	Due to (or as a consequence	e of):						
Box 68	death certifica e attending ph id for use as t	an/Med	230. Was decedent pregnant	c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal deat	th 3□	Ectopic pregnancy			23d. Da	ite of delive	ry
	that the dea led by the att detached fo	Physiclan/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐ Pregnant at time of death 9☐ Unknown		Other (specify)			Mo	onth	Day Year
ords, l	The law requires that the ste has been signed by th page 2 should be detache	by	Part II. Other significant conditions control	ibuting to death but not resulting	in the un	derlying cause give	n in Part I.		tobacco use cont Yes 2 No		e cause of death? ably 4 □Unknown
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/ita	cien; ertific ector,	Be (25. Was case referred to medical examiner?					Death (Check only			
0	Physi this c	^L	1 ☐ Yes 2 ☐ No ☐ Ho 27. Manner of Death	spital: 1 Inpatient 2 ER/O			INUISII	ng Home 5 Res)
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Division	Atten deal ctor; y the	Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined	28e. Place of Injury - At home, f building, etc. (Specify)	farm, stre		03 2 0,10	28f. Location (City or To	Street and Numb wn, State)	er or Rural	Route Number,
	To the Hospitel or , within 24 hours after To the Funerel Dire completely filled in b	edical C	29a. Certifier (Check only one) Certifying Physic 2 Medical Exemine	cian: To the best of my knowledger: On the basis of examination a and manner stated.	ge, death nd/or inve	occurred at the time estigation, in my opi	e, date and p inion, death o	lace, and due to the occurred at the time,	cause(s) and ma	inner as sta and due to	ated. the cause(s)
	To th withir To th comp	Me	29b. Signature and title of certifier			29c. License	number		29d. Date signe	d (Month, £	Day, Year)
	N		> /aws			D2	6511	6	Nov	1 8	2604
~	18/2		30 Name)a diaddress o son who com	pleted cause of death (Item 23a)	(Type, P		AVE	Gre	an o	21	202
	Sta Registr		31. Date filed (Month, Day, Year) NOV 0 9 200	32. R vistrar's Signature	6	Some	4				

		1	For State Registrar	State of	Marylan		artment rtificate				fental Hyg) 4	36774
			1. Decedent's Name (First, Middle	a, Last)							2. Date of Deat Month	h Day	Year	3. Time of Death
	Physicia /Medic Examin	al	Margaret 4a. Facility Name (If not institution	Lee n, give street and numb		D	iSimo 4b. City,		Location	of Death	Novembe		2004	6.32 P M
			Garrett County	Memorial	Hospit	al			akla				Garr	
T	Funeral		5. Social Security Number	6. Sex 7 1 ☐ M 2 ☑ F	. Age (In yrs.	last birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Birth (Month, Day,	Year)	Cour	
	Director		220-30-8161 Usual Residence of Decedent		71	115.	L				May 26,	1933	Ma	ryland
	Bud Mand		10a. State 10b. County		10c. City	y, Town or Lo	cation						1	Od. Inside City Limits
	Marylan feder	ঠ	MD	Garrett			0ak	1and	1					1 ☐ Yes 2∑ No
	r 28a	<u>s</u>	10e. Street and Number	Julius			10f. Zip	Code			1	0g. Citizen of	What Cour	ntry?
	h with	Funeral Director	1739 Underwood	Road				2	21550				USA	
	dear dear	Te.	11. Marital Status	12. Was Deced		.S. 13.	Was Deced	lent of Hi	spanic Ori n, Mexicar	igin? (Sp	ecify Yes or No- Rican, etc.)		ce - Americ ck, White,	can Indian, etc.
98	or it	F	1 Never Married 2 Marr	If Yes, Give		1	1 ☐ Yes 2					Specif	y: Wh	nite
Maryland 21215-0036	s 1 and 2 should be filled within 72 hours after death with the Maryland of Health end Mental Hyglane. Item 27 is marked other than "neturel", or Items 23s or 2ss-(show other traumatic avent, Its Marical Examinar must be notified at	d by	3 Widowed 4 Divorced	Year or Dat	es:	16a Dece	dent's Usua	I Occupa	ation			16b. Kind of B	usiness/In	dustry
15	n 72 net	Completed	(Specify only highe	1		(Give	kind of wor DO NOT us	k done d	<i>luri</i> ng mos	t of work	ring	TOD. TUITO OF D	Q31110332111	doday
12	withi ane.	E	Elementary/Secondary (0-12)	College (1-4	4or 5+)		Hous	ewif	e				Home	
9	Hygir other		17. Father's Name (First, Middle,	Last)	-				18. Moth	er's Nam	e (First, Middle, M	Maiden Surnar	ne)	
a	lid be lentai rked o	10 B	Burlin	Columbus	3	Но	11er		E1	sie	Ма	e	Hine	baugh
ary	2 should be end Mental is marked (aumatic av		19a. Informant's Name/Relations	hip (Type, Print)			-				al Route Number,			Code)
	is 1 and 2 of Health e item 27 is other tra		Joseph F. DiSi	mone/husba							Oakland,		_	
Baltimore,	of He		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation	3 □Removal from S	tate 20b. P	Place of Dispo cemetery, crea	osition (Nan matory or o	ne of ther plac	e)		Date	20c. Location	- City or To	own, State
Ĕ	permit. Peges i Department of H Importent: If ite eny injury or ot once.		'4 □ Donation 5 □ Other (S		Gar	rett (15/04	0aklan	d, Ma	ryland
alt	Departi Departi Import eny Inj		21. Signature of Funeral Service	Licensed	1		2. Name an				tewart F			2
_	20E 2 9		Slowly	11- Alle	A						Oakland,		1550	Approximate
	Pnysician /Medical		23a. Part1. Enter the disease, of shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)	a. Renal	ch line. L failu ras a conseq	ıre	ter the mod	e or dyin	y, such as	Cardiac	or respiratory arre	,		Interval Between Onset and Death Months
1	Examiner		Sequentially list conditions,		etes ty									years
	70 ==	Ē	if any, leading to immediate cause. Enter Underlying	Due to (o	r as a conseq	uence of):								
	ate be executed hysician and the buriel-trensit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	C. Due to (c	or as a conseq	mence of).								
760,	clan s	ũ	, , , , , , , , , , , , , , , , , , ,	00000	as a conseq	juerice or).								
687	physi the t	dical		d										
.O. Box 6	requires that the death certificat een signed by the attending phy hould be detached for use as th	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown		th 2 ☐ Fete intattime of d	death 3	⊒Ectopic pr ⊒ Other (sp						ite of deliver	ery Day Year
Records, P.	uires that the deatt isgned by the atte id be detached for	d by Ph	Part II. Other significant conditi	ons contributing to dea	ath but not res	ulting in the u	anderlying c	ause give	en in Part	I.	23e. Did tob		tribute to t	he cause of death? pably 4 Unknown
S		Completed									24a. Was a	n 24b.	Were auto	psy findings available impletion of cause of
Re	The law rate has by paga 2 sh	Ë									autops perform	ned?	death?	
VItal		0	25. Was case referred to medica	1					26. Plac	e of Dea	th (Check only on			
Ξ	Physicien: this certific rai director,	To B	examiner?	Hospital:	patient 2	ER/Outpatie	nt 3 DC	Oth	er: 4 □ N	ursing H	ome 5 Reside	ence 6 Oth	ner (Specil	5)
lon of	Attanding Ph r death. ector: After th by the funeral		27. Mono of Death Natural 5 Pendi		f Injury n, Day Year)	28b. Time o Injury	of 2	8c. Injun Worl	yat k? Yes 2. □]No	28d. Describe ho	ow injury occur	red	
Division	after des after des I Director d in by the	Certification;	3 Suicide 6 Could 4 Homicide determ	nined 289. Place	of Injury - At higg, etc. (Specil	ome, farm, st	reet, factory	y, office			28f. Location (St City or Town		ber or Run	al Route Number,
	To the Hospital or Attanding Physicien: within 24 hours after death. To the Funsrel Director: After this certific completely filled in by the funeral director.	edical C	29a. Certifier 1 Certifying (Check only 2 Medical one)	ng Physician: To the Examiner: On the ba	sis of examina	owledge, dea ation and/or in	th occurred nvestigation	at the tin	ne, date ar pinion, dea	nd place, ath occur	and due to the carred at the time, da	ause(s) and mate and place,	anner as s and due t	tated. o the cause(s)
	To the To the comple	Me	29b. Signature and title of bertific	n			290	c. Licens	e number	~ 7 ~	37 2	9d. Date signe	d (Month,	Day, Year)
	D		30, Name and address of person	who completed cause	of death (Iter	m 23a) (Tvoe	Print)		7. 9	2		1//		7
	(4		Thomas Johns		11 N.			0ak1	and.	Md.	21550	/		/
	Sta Regist	ate rar	31. Date filed (Month, Day, Year		gistrar's Signa	ature	224							

		•	For State Registrer	State of M	faryland /	•	artment of F		nd Me		ene	0001	
	Physici /Medic		Decedent's Name (First, Middle, William Eugene						1	. Date of Death Month Ovember	Day	2004	3. Time of Death 5
	Examin	er	4a. Fecility Name (If not institution, Cuppett-Weeks N	ursing Home	2		4b. City, Town, o Oaklan	ıd				ounty of Death Sarrett	
	Funeral Director		5. Social Security Number 213–36–6320 Usual Residence of Decedent	6. Sex 1	ige (In yrs. last bi	irthday) Yrs.	If Under 1 Year Months Days	If Under 2 Hours	Min.	Date of Birth (Month, Day, Apr 1,	^{Year)} 1940	Cour	place (State or Foreign http) yland
	Maryland f show	tor	10a. State 10b. County MD Garret	t	10c. City, Tov							1	0d. Inside City Limits 1 ☑ Yes 2 ☐ No
	h with the 23a or 28a at be noti	al Director	10e. Street and Number 26 Park Street				10f. Zip Code 21	531		10	-	of What Cour	ntry?
980	hours after death with the Maryland tural', or Items 23a or 28a-f show the Exercitive froutil be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Marrie 3 ☑ Widowed 4 □ Divorced	12. Was Decedent Armed Forces ad 1 Tyes 2 X If Yes, Give Year or Dates:	:?] No		Was Decedent of H if Yes, specify Cuba 1 ☐ Yes 2 ☑ No	ispanic Orig an, Mexican, Specify:	in? (Specif Puerto Ric	y Yes or No- can, etc.)		Race - Americ Black, White, pecify: Whi	etc.
Maryland 21215-0036	within 72 ane. than "nat	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12)		5+)	(Give life.	dent's Usual Occup kind of work done DO NOT use retired Denter	during most	of working			of Business/Ind	onstruction
land 2		To Be C	17. Father's Name (First, Middle, L. Carl Dixon	ast) .					's Name (F	First, Middle, M			MOCE de Calon
Mary	s 1 and 2 should if Health and Men item 27 is marks other traumatic		19a. Informant's Name/Relationshi William E. Dixo				ng Address (Street nestnut G						
Baltimore,			20a. Method of Disposition 1 Burial 2 □ Cremation 3 1 □ Donation 5 □ Other (Specific Properties)		cemete	ery, crei	sition (Name of natory or other place Rose Cem		Date 13, 2	-		tion - City or To	
Balt	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service Li	Deum	and	117	Name and Address Wman Fun 79 Miller	St.,	Grant	sville	, MD		
8760,	death certificate be executed Exam e attending physician and id for use as the burial-transit	dicai Examiner	23a. Part1. Enter the disease, or control shock, or heart fediure. List of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, any learned to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a.D. B. B. B. B. B. B. B. B. B. B. B. B. B.	s a consequence necroti s a consequence c obstr s a consequence	of): Zir of): UCt	ng pneum	nonia Lmona				3	Approximate Interval Between Onset and Death days mo yrs
.O. Box 68	that the death certifici led by the attending pl detached for use as t	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		e of pregnancy 2 Petel death at time of death		Ectopic pregnancy Other (specify)				23d	Date of delive	ory Day Year
S, D	sign d be	ed by Ph	Part II. Other significant condition decubiti	s contributing to death	but not resulting	in the u	nderlying cause give	en in Part I.					ne cause of death?
al Record	The law ate has b page 2 st	Completed by						-	_	24a. Was an autopsy perform		4b. Were autoprior to condeath?	osy findings available inpletion of cause of
on of Vital	ding Physicien: Th h. After this certificate funeral director, pag	tion; To Be	25. Was case referred to medical examiner? 1 □ Yes 2 ☑ No 27. Manner of Death 1 □ Natural 5 □ Pending investigations.		ury 28b.	utpatien Time of Injury	28c. Injun Worl	er: 4 □XNurs	sing Home	Check only one 5 ☐ Residen 1. Describe how	ice 6 🗆	Other (Specify	·)
Division	spital or Attending ours after death, nerel Director: After filled in by the funer	Certification;	2 Accident Investiga 3 Suicide 6 Could no 4 Homicide determin	ot be 28e. Place of In	njury - At home, fa atc. (Specify)	arm, str	eet, factory, office			. Location (Stre City or Town,		lumber or Rura.	l Route Number,
	9 t 4 t 9 t 9	Medical C	29a. Certifier 1 Certifying (Check only one) 2 Medical E	Physicien: To the best xeminer: On the basis of and manner s	of examination ar	e, death	occurred at the time restigation, in my of	ne, date and pinion, death	place, and	due to the cau at the time, dat	use(s) and e and pla	d manner as st ice, and due to	ated. the cause(s)
)	To the le within 2 To the Complet	Me	29b. Signature and title of certifier	RRcha	500		29c. License D300					igned (Month, L	
	N		30. Name and address of person w	the completed cause of			Print) Memoria	1 Dr	ive (naklan	d '	MD 215	50
	Sta Registr	_	31. Date filed (Month, Day, Year)		trar's Signature	2	Andi	. 	_ +	Julian	. ,	. I D - E I J	. 50

			For State Registrar	State of Maryla		artment of F			ene g. NG 004	36776
	Physici	an	1. Decedent's Name (First, Middle, Last)					2. Date of Death Month	Day Year	3. Time of Death
	/Medic	al	John Denni: 4a. Facility Name (If not institution, give s			4h City Town o	r Location of Deat	Novembe:	4c. County of Deal	5:10 P M
	Examin	er	Garrett County Mem		cal	Oakla	_		Garrett	
Ī	Funeral Director		102-10-0020	M 2□F 7. Age (In y	rs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.	(Month, Day,	9. Birt Co 0 1924 Mar	hplace (State or Foreign untry) yland
	land		Usual Residence of Decedent 10a. State 10b. County	10c.	City, Town or Lo	ocation				10d. Inside City Limits
	Mary a-f sh	tor	MD. Allegan	У	Western	port				î ∛ Qã∕es 2 ∏ No
	th with the 23a or 28 ist be not	ai Director	10e. Street and Number 117 McKinley	St.		10f. Zip Code 21562	2	10	og. Citizen of What Co United St	
980	72 hours atter death with the Maryland naturel', or items 23e or 28e-f show iteal Examirer must be notified at	by Funerai	11. Marital Status 1 Never Married X Married 3 Widowed 4 Divorced	2. Was Decedent Ever in Armed Forces? 1XX es 2 □ No V If Yes, Give Year or Dates:	VVVZ	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2XIINo	lispanic Origin? (S an, Mexican, Puer Specify:	Specify Yes or No- to Rican, etc.)	14. Race - Ame Black, Whit Specify: W	
Maryland 21215-0036	within ene. than "	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12) UNKNOWN	cation completed) College (1-4or 5+)	(Give	dent's Usual Occup kind of work done DO NOT use retired	during most of wo d)	rking	6b. Kind of Business, Photograph	1
/land 2	ba tile ital Hyg od othe event,	To Be C	17. Father's Name (First, Middle, Last) John W. Deni	nison			18. Mother's Nai	me (First, Middle, M	faiden Sumame)	
Man	12 sh h and 7 is m traum		19a. Informant's Name/Relationship (Type Margaret Dennison/			ng Address <i>(Street l</i> IcKinley S			City or Town, State, 2 , Maryland	
Baltimore,	of H of H fiter		20a. Method of Disposition 103 Burial 2 Cremation 3 Re 4 Donation 5 Other (Specify)	emoval from State	cemetery, crei	psition (Name of matory or other place Iem. Garde		/14/ K	oc. Location - City or eyser, Wes	Town, State t Virginia
Balti	permit. Pag Department Important: I any injury o		21. Signature of Funeral Service License	Boal		2. Name and Address 11 Church	-	Boal Funer	ral Home t, marylan	d 21562
	Pnysician		23a. Part1. Enter the disease, or complice shock, or heart failure. List only on Immediate Cause (Final disease or condition	cations that caused the de e cause on each line.	eath. Do not ent					Approximate Interval Between Onset and Death 24 hours
ı	/Medical Examiner		resulting in death) Sequentially list conditions,	Due to (or as a cons		rterioscl	erosis			years
	be executed sician and burial-transit	Examiner	di any, leading to an modiate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to for as a cons	Hy	yperchole	sterinem	ia		years
8760,	cate be ex ohysician the burial	cai	d	Due to (or as a cons	equence or).					
.O. Box 6	ne death certifi the attending p thed for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	3c. If yes, outcome of pred 1 Live birth 2 F 4 Pregnant at time of 9 Unknown	etal death 3	□Ectopic pregnancy □ Other (specify)			23d. Date of del Month	very Day Year
Δ.	quiras that the signed by ald be detacted	ρ	Part II. Other significant conditions con	tributing to death but not	resulting in the u	inderlying cause giv	en in Part I.	23e. Did toba	acco use contribute to s 2.□No 3□Pr	the cause of death?
Records,	The ate h page	Completed						24a. Was an autopsy perform	r prior to d	topsy findings available completion of cause of
Vital	ician: Th certiticate rector, pag	Be	25. Was case referred to medical examiner?	annital:				ath (Check only one)	
of	ing Phys ineral di	lon: To	27. Manne of Death Natural 5 Pending	ospital: 1 Inpatient 2 28a. Date of Injury (Month, Day Year)	ER/Outpatier 28b. Time o Injury	f 28c. Injur	4 Nursing F	Home 5 ☐ Resider 28d. Describe how	nce 6 Other (Spec w injury occurred	city)
Division	in District	Certification:	2 Accident 3 Suicide 6 Could not be determined	28e. Place of Injury - A building, etc. (Spe				28f. Location (Str. City or Town,	eet and Number or Ru State)	ral Route Number,
	e Hospital 124 hours a le Funeral l letely filled	edical C		sicien: To the best of my ler: On the basis of exame and manner stated.						
	To the vithin 2 To the comple	Me	29b. Signature and title of certifier			29c. Licens	e number	29	d. Date signed (Monti	n, Day, Year)
	N		1 Th	un		D	1355	5	11/11/0	1
.1	1/5		30. Name and address of person who co Dr. Thomas Johns	son 311 N.	4th St.	Oakland,	Md. 215	550		
	Sta Registi		31 Date filed (Month, Day, Year)	32. Régistrar's Si	gnature	free to				

				Pleas	• •					-	Are Legib	le.				
			1 - For State Registrar		State o	f Maryla		artment of rtificate of		Mental Hyg	gienje () () [Reg. No.	* 367	17			
	Physici /Media		1. Decedent's Name Paulin		ast) :khead	Dear	ı			2. Date of Dea Month Novembe		3. Time of 0 004 3:06				
	Examir		4a. Facility Name (#		ive street and nur sing Cen				or Location of Dea Lardtown	th	4c. County of St. M	Death [ary s				
	Funeral. Director		5. Social Security No. 577-20-8	629	Sex 1□M X F	•	rs. last birthday) 81 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min		v, Year)	D. Birthplace (State or Country) Washington	_			
	aryland ehow	_	Usual Residence of 10a. State	10b. County		10c.	City, Town or Lo	ocation				10d. Inside City				
	th the M or 28e-f	irecto	Maryland 10e. Street and Nur		lary's		Hollywoo	10f. Zip Code			10g. Citizen of Wh		43,28 ,10			
	23e	alC	24991	Briscoe	Road			20636	6		U.S.A.					
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other then "naturel", or items 23e or 28e-f ehow with injury or other treumatic event, The Medical Examinar must be notified at ADGE.	by Funeral Director	11. Marital Status 1 Never Marri 3 Widowed	-	If Yes, Gi	rces? 2 X No /e	1	Was Decedent of If Yes, specify Cub 1 ☐ Yes 2 ▼ No		Specify Yes or No- to Rican, etc.)	14. Race - Black, Specify: V	American Indian, White, etc.				
8	hour turel	pa pa	3 = **Idowed	15. Decedent's	Year or D	ates.	16a Dece	dent's Usual Occu	nation		16b. Kind of Busin					
21215-0036	within 72 ene. then "na:	Completed	(Spec Elementary/Second 12	ify only highest	College (I-4or 5+)	(Give		during most of wo	orking	Own Ho					
d 2	filed Hygi ther		17. Father's Name (First, Middle, La	st)		1202		18. Mother's Na	me (First, Middle,	Maiden Surname)	<u> </u>				
an	d be ental ced c	To Be	Russell	Robert	Birckhea	ıd			Margar	et Certri	ude Blund	lon				
Maryland	shoul nd M marl	-	19a. Informant's Na				19b. Maili	ng Address (Stree			r, City or Town, Sta					
Š	nd 2 Ilth a 27 ie r treu		Warren W	. Dean /	Husband	l	24991	Briscoe	Road Ho	llywood,	Maryland	1 20636				
ē,	s 1 au f Hea item othe					- 1	b. Place of Dispo	sition (Name of		Date						
Baltimore,	Page ent o nt: If ry or						•		. 1	-2004	Arlinoto	n Virvin	ia			
alt:	mit. I		**Burial 2 Cremation 3 Removal from State '4 Donation 5 Other (Specify) Arlington National 12-6-2004 Arlington,													
ä	Depa Impo eny ii	H	David													
	Physician /Medical Examiner		23a. Part1. Enter the shock, or hear shock, or hear shock, or hear shock, or hear shock, or hear shock, or hear shock, or heart shock, or hear	Final n	a. Non Due to b.	Sma (or as a cons	sequence of):		2 Conc		est,	Approximate Interval Betw Onset and Di	een			
	cuted nd iransit	Examiner	cause. Enter Unde Cause (Disease or that initiated events	rlying injury	С	`	sequence of):									
68760,	eath certificate be executed attending physician and for use as the burial-transit		resulting in death) L	ast	Due to	or as a cons	sequence of):									
O. Box	The law requires that the death certificate be executed tite has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent in the past 12 1 Yes 2 Unknown			ointh 2 ☐ F ant at time o	etal death 3[Ectopic pregnand Other (specify)	ey .		23d. Date of Month		ear .			
Records, P.	uires that n signed b	þ	Part II. Other signifi	_	_	eath but not	resulting in the u	nderlying cause gi	ven in Part I.	23e. Did to		ite to the cause of de □ Probably 4 □Ur				
000	w requir	iete	- Acth	vysema rma						24a. Was a		re autopsy findings av	vailable			
al Re	iclen: The lav certificate has rector, page 2	Completed									med? dea 2 No 1 □	r to completion of cal	use of			
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on of Vital	ing Physicien: After this certifica funeral director,	ion; To	1 Inpatient 2 EH/Outpatient 3 DOA 4 Nursing Home 5 Residence								(Specify)					
Division	To the Hospitel or Attending Physicien: The within 24 hours after death. To the Funerel Director: After this certificate his completely filled in by the funeral director, page	Certification:	2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide	6 Could not determine	be 28e. Place	of Injury - A ng, etc. (Spe	t home, farm, str ecify)	eet, factory, office		28f. Location (Si City or Town	treet and Number on, State)	or Rural Route Numbe	Эг,			
	To the Hospitel or A within 24 hours after To the Funerel Direct completely filled in by	Medical C	29a. Certifier (Check only one)	1 Certifying 2 Medical Ex	aminer: On the ba	best of my in asis of exam her stated.	knowledge, death ination and/or in	n occurred at the tivestigation, in my	ime, date and place opinion, death occ	e, and due to the curred at the time, d	ause(s) and manne late and place, and	er as stated. I due to the cause(s)				
	To th within To th compl	Me	29b. Signature and	The of entifier	7 1	M	7		se number	2	9d. Date signed (A	Month, Day, Year)				
	NO		14	a nasti	Tuel de		MD	D5.	2196		November	15, 2004				
4	2		30. Name and addre					Print)		enter Uc	llywood,					
	Sta Regist		31. Date filed (Mont		32. R	egist/ar's Sig	gnature e	Anna SI	TOPPING C	enter no.	TTAMOOG,	EID 70020				

Registrar DHMH 17 Rev 1/2001 B.K.S DANIEL DARIENZO

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

LĿ	L DAKIE	كالالك	For 1_ State		State of Ma	aryland				Mental Hy	giene	9	
			Registrar	ddlo I a	200		Cer	tificate of I	Deall	2. Date of De	Reg. No	2004	3 Time of Death
	Physici	an	1. Decedent's Name (First, Mi							Month NOV.	Da	2004 Year	0205 A ^M
	/Medic		Daniel Raym 4a. Facility Name (If not institu					4b. City. Town, or	r Location of Death			County of Death	0203 A
	Examin	ier	PRINCE GEOR	. •		CENTE	:R	CHEVER		,		PRINCE (GEORGES
	Funeral		5. Social Security Number	6. S			ast birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Bir	th Vana	9. Birthr	place (State or Foreign
	Director		213-21-5664	1	XM 2□F 19	9	Yrs.	Months Days	Hours Min.	8. Date of Bir (Month, Da Dec. 2,	198	34 Mary	place (State or Foreign http:) 7 Land
	p _		Usual Residence of Decedent			40- 03	7					Τ.	lod tasida Oir Limita
	anytar show	_	10a. State 10b. Cou	nty		-	, Town or Lo	cation					10d. Inside City Limits 1 ☐ Yes 2X No
	Ba-f	ecto		ert	County	Owi	ngs	10f. Zip Code			10g Cit	izen of What Cou	
	with t	ä	10e. Street and Number		D= - 4			20736			-	S.A.	ту:
	eath	Funeral Director	5750 Johns Ch	apeı	12. Was Decedent I	Ever in U.S	S. 13. V	Was Decedent of H	lispanic Origin? (S	pecify Yes or No		14. Race - Americ	
	r Iten	표	1 Never Married 2 □ N	Married	Armed Forces? 1 □ Yes 2 X					o Rican, etc.)		Black, White,	
3	al', o	by	3 ☐ Widowed 4 ☐ Divord		If Yes, Give Year or Dates:			1 ☐ Yes 2 X No	Specify:			Specify: Whi	LLE
0200-01	be filed within 72 hours after death with the Maryland tal Hygiene. Id other than "natural", or Items 23a or 28a-f show other than "natural", or Items 23a or 28a-f show event, the Medical Examinational talling at	Completed	15. Dece (Specify only hig	dent's Ed	ducation ade completed)		16a. Deced	tent's Usual Occup kind of work done o DO NOT use retired	ation during most of wor	king	16b. K	ind of Business/In	dustry
7	nthin ne. han	Idu	Elementary/Secondary (0-1	Ť	College (1-4or 5	i+)			1)		,	College	
7	fygiel har tl		17. Father's Name (First, Midd	tlo last	+1		Stu	ident	18. Mother's Nan	ne (First Middle	_		
	2 should be filed within and Mental Hygiene. Ia marked othar than aumatic evant, the Ma	Be	Raymond V. D'							McCune			
Ž	should nd Men marke umatic	2	19a. Informant's Name/Relation				19b. Mailin	ng Address (Street			er. City o	or Town, State, Zin	Code)
<u>8</u>			Raymond V. D			er)	5750	Johns Ch	anel Road	d Owing	rs. I	Maryland	20736
ē,	s 1 and of Health itam 27 other tr		20a. Method of Disposition				lace of Dispo	sition (Name of natory or other place	Nove	nber 6,	20c. L	ocation - City or To	own, State
Ē	Pages nent of I ant: If its ury or o		1 ☐ Burial 2 ☐ Cremation 1 ☐ Donation 5 ☐ Other				ohnVia	anneyCh.C	em. 2	004			erick, MD
Бант	- + - -		21. Signature of Funeral Servi	ice Lice	809		22	. Name and Addres	ss of Facility Le	e Funera	ıl Ho	ome Calve	ert, P.A.
מ	Depar Depar Impor any ir		Miebael V	L	e		81	125 South	ern Mary	land Blv	7d.,	Owings,	MD 20736
			23a. Part1. Enter the disease shock, or heart failure.	, or com List only	plications that caused one cause on each lir	the death	. Do not ent	er the mode of dyin	g, such as cardiad	or respiratory a	rrest,		Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition		a 1500 V.) -	Dasc	mus					Oriset and Death
	/Medical Examiner		resulting in death)		Due to (or as	a consequ	ience of):						
	LAdiminet	<u>.</u>	Sequentially list conditions,		b. Due to (or as	2 0000000	ience off:						
	pet nsit	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	≺	200 10 (01 40	a oorloods	301100 01).						
	al-tra	Examiner	resulting in death) Last	-	Due to (or as	a consequ	ience of):						
ρα/ρη,	death certificate be executed e attending physician and id for use as the burial-transit	edical		l	_ d								
Q	tificat og phy as th												
ŏ	th cer tendir r use	an/h	IF FEMALE: 23b. Was decedent pregnant	ļ	23c. If yes, outcome 1 ☐ Live birth			Ectopic pregnancy	1			23d. Date of delive Month	ery Day Year
מ	e dea the att	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		4□ Pregnant at 9□ Unknown	time of de	eath 5	Other (specify)				MONU	Day
л Э	w requires that the death certific been signed by the attending p should be detached for use as	Phy	Part II. Other significent cond	ditions	contributing to death b	ut not resu	ulting in the u	nderlying cause give	en in Part I	23e. Did t	obacco i	use contribute to the	ne cause of death?
ds,	signe d be	d by	Takin outot olgimooni o					, , , , , , , , , , , , , , , , , , ,		10	Yes 2	No 3 Prob	pably 4 Unknown
cords	v requ been shoul	Completed								24a. Was	an	24b. Were auto	psy findings available
ř	has has	mp								autop perfo	osy rmed?/	prior to co	mpletion of cause of
VITAL	ician: Th certificate rector, pag	e Co	25. Was case referred to med	lical					26. Place of Dea	th (Check only o	2 No	1 ☐ Yes	2□ No
	tanding Phyaician: leath. tor: After this certific the funeral director,	0 8	examiner? 1 X Yes 2 □ No		Hospital: 1 ☐ Inpatie	nt 2XX	ER/Outpatien	it 3 DOA Oth	or			6 □Other (Specif	y)
0	g Ph ter th	T:U	27. Manner of Death	- dia a	28a. Date of Inju	ry v Year)	28b. Time of Injury	28c. Injur	y at k?	28d. Describe I	,	,	
0	r Attanding I er death. ractor: After by the funer	atic	E E I TOOIGOTIL	estigatio	10-30-	04	03001		Yes 2 No	VRUEN	DKC	DRIMPIX	swith polo
DIVISION	l or Attandatter death Diractor:	Certification:		uld not b ermined	e 28e. Place of Inju- building, etc.	ury - At ho c. (Specify	me, farm, str	eet, factory, office		City or Tox	vn, State		(M)
	ital o rrs af ral D lled ir												गंद प्राम्ह क
	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	Medical	29a. Certifier 1 Certi (Check only 2 Medi one)	tying Pr cel Exai	nysician: To the best of niner: On the basis of and manner sta	examinat	wiedge, death tion and/or inv	occurred at the tin vestigation, in my o	ne, date and place pinion, death occu	red at the time,	date and	and manner as s place, and due to	tated. the cause(s)
	o the ithin (Med	29b. Signature and title of cer	tifier	and training ste			29c. Licens	e number		29d. Da	te signed (Month,	
	F 5 ₩ 3		MICHANT	0.	The Mail	o lu	0	0.	C.M.E		N	ov. 2, 2	2004
			30. Name and address of pers	son who	completed cause of d								
	4		MARLOMAN	D	· Koren			nn Street		ore, Mai	yla	nd 21201	
	Sta		31. Date filed (Month, Day, Yo	ear)	32. Registra 4 2004	Signal	ture	1					
	Regist	rar	146	VYU	4 4 4 4 4	COLLER	1 15.	Boste					

	•	For State Registrar	State of Marylar	·	ent of Health ar ate of Death		giene No. 2001	3677
Division		1. Decedent's Name (First, Middle, Li	ast)			2. Date of Dea Month	ith Day Year	3. Time of Death
Physicia /Medic		Mildred	Ruth	Evans			30, 2004	9:05 p
Examin	-41	4a. Fecility Name (If not institution, gi	ve street and number)	4b. (City, Town, or Location of D	Death	4c. County of Dee	th
		Wilson Health (Care Center		aithersburg		Montgom	ery
Funeral		Social Security Number 6.	Sex 7. Age (In yrs. 1 ☐ M 2 反 F	Mon	nder 1 Year If Under 24 ths Days Hours	Min. (Month, Da)	(, Year) C	thplace (State or Fore ountry)
Director		218 42 7345 Usual Residence of Decedent	91	Yrs.		Aug. 1	6 1913 Vi	rginia
and w		10a. State 10b. County	10c. Ci	ity, Town or Location				10d. Inside City Limi
within 72 hours after death with the Maryland ene. Than "natural", or lems 23a or 28a-f show the Modical Exeminer must be notilled at	ö			4.1				1 🗆 Yes 2
28a-	by Funeral Director	Maryland Montgo 10e. Street and Number	mery Ga	ithersbur	g . Zip Code		10g. Citizen of What Co	ountry?
Mith Ba or	ō	201 Russell Avenu			20877		USA	
ms 2	era	11. Marital Status	12. Was Decedent Ever in U	J.S. 13. Was D	ecedent of Hispanic Origin	? (Specify Yes or No-	14. Race - Ame	
or Ite	Ē	1 Never Married 2 Marned	Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give		specify Cuban, Mexican, F	'ueπo Hican, etc.)	Black, Whi	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Inportant: if term 27 is marked other than "natural; or liems 23a or 28a-1 show any injury or other traumatic event, the Madical Examiner must be notified at once.	by	3 Widowed 4 □ Divorced	Year or Dates:	1 76	s ZEN o Specify:		Specify: W	hite
72 ho	Completed	15. Decedent's E (Specify only highest gi	ducation	16a. Decedent's	Usual Occupation f work done during most of	working	16b. Kind of Business	/Industry
- L	npie	Elementary/Secondary (0-12)	College (1-4or 5+)	life. DO NO	T use retired)			
Hygier Hygier other th	S		4	Nu	rse			Health Ser
d oth	Be	17. Father's Name (First, Middle, Las	t)		18. Mother's	Name (First, Middle,	Maiden Sumame)	
snould be ind Mental marked o umatic eve	ဥ	John Richard Ear				h Rosser		
and ls m		19a. Informant's Name/Relationship			ress (Street and Number of			
ariu lealth m 27 her tr	1	Jeffrey Bald / A			of Gloucest			
nent of H		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3		Place of Disposition cometery, crematory	or other place)	Date	20c. Location - City or	Town, State
a Hand		4 □ Donation 5 □ Other (Spec	Ft	Lincoln	Crematory 11	/6/2004	Brentwood,	Maryland
Departr Importu any inj		21. Signature of Funeral Solvior Lice	inse	22. Nam	e and Address of Facility	ines Rinal	di Funeral	Home
10 E # 9		23a. Part1. Enter the disease, or cor	sewden-		0 New Hampsh			g, MD 2090 Approximate
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physicien the buria	cat		d					
deain certification at the set	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome of pregni 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of co	al death 3 □Ectop	ic pregnancy (specify)		23d. Date of de Month	livery Day Year
0 0		3 - Olikilowii						
0 5	Phy	Part II. Other eignificant conditions	contributing to death but not res	sulting in the underly	no cause diven in Part I	23e Did to	hacco use contribute to	the cause of death?
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** PVANS 02 23:12 M OVELLA /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner WASHINGTON ADVENTIST HOSP. Montgomery Takoma Park If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6. Sex **Funeral** 1 □ M 2 □ F 58 422-62-4608 Alabama Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County ortant: If item 27 is marked other than "natural; or items 23a or 28a-1 show injury or other traumatic event, the Medical Examinat must be notified at 1 ¥Yes 2 □ No Be Completed by Funeral Director Prince Georges Forestville 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 2508 Oak Glen Way 20747 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 XNever Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Specify black 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry DC Govt./Court f Health and Mental Hygiene. Item 27 Is marked other than Elementary/Secondary (0-12) College (1-4or 5+) motions clerk 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be Martha Williams Johnnie Neal Evans Jr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2508 Oak Glen Way Forestville, MD 20747 Marcus Evans/son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages Department of Important: If its 1 ■ Burial 2 □ Cremation 3 □ Removal from State
'4 □ Donation 5 □ Other (Specify) Resurrection Cem 11/9/04 Clinton, MD Name and Address of Facility
K Henry Funeral Chapel Inc. 21. Signal of Funeral Service M01178 420 H Street NE Wash DC 20002 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) SEPSIS **Physician** /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner The law requires that the death certificate be executed use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): physician Division of Vital Records, P.O. Box 68760 Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Saknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an funeral director, page 2 autopsy 2 2 00 certificate 2 No 1 Yes 1 Yes or Attending Physician: 25. Was case referred to medical examiner?
1 Xes 2 No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 ER/Outpatient 3 □ DOA 1 Inpatient Medical Certification: To After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 1 (XN)atural 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending after death. 1 TYes 2 No investigation 2 Accident completely filled in by the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide within 24 hours To the Funeral 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of pertifier 29c. License number 29d. Date signed (Month, Day, Year) who completed cause of death (Item 23a) (Type, Print) ammer 31. Date filed (Month, Day, Year) Registrar's Signature State NOV 0 8 2004 Registra

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 5 , **Physician** 2004 5:10 PM Laurence King Foote Jr. November /Medical 4a. Facility Name (If not institution, give street and number) 4b, City, Town, or Location of Death 4c. County of Death Examiner Reeders Memorial Home Washington Boonsboro 8. Date of Birth (Month, Day, Year) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign
 Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1**⊊**M 2□F 1918 Director 041 - 05 - 945786 Usual Residence of Decedent with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits ust be notified at 1 Yes 2 No Middletown Completed by Funeral Director MD Frederick 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 6522 Morningside Ct. 21769 USA Items 23a 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 0 / 0 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) other traumetic event, the Madical Examiner. Armed Forces? 1942 — 1 Gyes 2 □ No 1942 — If Yes, Give Year or Dates: 1946 1 Never Married 2 Married 0 1 ☐ Yes 21 No Specify: Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) medical lab controller 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Maryland Be eq pinous Laurence K. Foote Sr. Olive Russell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Madelene Foote (Wife) 6522 Morningside Ct., Middletown, MD 21769 If itam 27 Baltimore, 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of Hi
Important: If ital
any injury or oth 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State
4 ☐ Denation 5 ☐ Other (Specify) Smithsburg Creamtory11/7/04Smithsburg, MD Bonald dd B. Thompson Funeral home Signature of Funeral Service Licenses 31 E. Main St., Middletown, MD 21769 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure. List only one cause of each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of): burial-transit Hospital or Attending Phyaician: The law requires that the death certificate be executed Due to (or as a consequence of): the l IF FEMALE use a 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significent conditions contributing to death but got resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Munknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy 2 No 1 ☐ Yes Be 25. Was case referred to medicat examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Vursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 70 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No after death. 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) þ determined 4 | Homicide filled in within 24 hours a To tha Funeral (Pertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number Novemb 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1+1

Registrar DHMH 17 Rev 1/2001 Zafar Malik

NOV 0 8 2004

31. Date filed (Month, Day, Year)

Box 68760.

P.O. |

Road.

Boonsboro, MD

21713 301-432-

8470

20311 Lappans

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 200 L 36782 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) November 3, 2004 Physician 2:00 a. M Martha Forst /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Frederick Mt. Airy 531@ Concord Court If Under 1 Year If Under 24 Hrs. A Date of Birth (Month, Day, Nov. 1, Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days 1 ☐ M 2**)**F 89 488-16-9242 Yrs. Kentucky Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes Z No Directo Frederick Mt. Airy Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21771 United States 5310 Concord Court Completed by Funeral 14. Race - American Indian, Black, White, etc. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Yes 2 Mo If Yes, Give 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No Specify: If Yes, Givo Year or Dates: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Importent: if item 27 is marked other than "I any lijury or other traumatic event, tra Mag once. Elementary/Secondary (0-12) College (1-4or 5+) Own Home 12 Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ida Schuhmann Harry C. Kennedy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5310 Concord Street, Mt. Airy, MD 21771 Suzanne Burkhardt / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State St. Michael's Cem. Nov. 6,2004 Poplar Springs, MD * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Stauffer Funeral Home 21. Signature of Funeral Service Licensee 1621 Opossumtown Pike, Frederick, MD 21702 ourtre Pen 1. Enter the dis a shock, or heart failure e, or complications that reside the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) mensur

Physician /Medical Examiner

death with the Maryland

1 and 2 should be filed within 72 hours after i Health and Mental Hvniana

Baltimore, Maryland 21215-0036

ral', or Items 23e or 28e-f show Examiner must be notified at

"netural" er than "netur.

attending physician and

þ Director: / filled in by

The law requires that the death certificate be executed

Hospital or Attending Physician:

within 24 hours at To the Funeral D

29b. Signature

30 Name

and address of

Robert\ 31. Date filed (Month, Day, Year)

NOV 05

2004

Division of Vital Records, P.O. Box 68760,

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consect d	,				
IF FEMALE: 23b. Was decedent pregnant in the past 12 menths? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregn 1 □ Live birth 2 □ Fet 4 □ Pregnant at time of 9 □ Unknown	al death 3 □Ectopic			23d. Date of deliver Month D	y Day Year
Part II. Other significant conditions of	ontributing to death but not re	sulting in the underlying	cause given in Part I.		prior to com death?	
25. Was case referred to medical examiner?	Hospital: 1 ☐ Inpatient 2 ☐]ER/Outpatient 3□ 0	Other	eath (Check only one) Home Residence	6 □Other (Specify)	
27. Manner of D ath 1 Natural 5 Pending Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. escribe how in	ijury occurred	
3 Suicide 6 Could not be determined	28e. Place of Injury - At the building, etc. (Spec.	nome, farm, street, factorify)	ry, office	28f. Location (Street City or Town, St	and Number or Rural ate)	Route Number,
	ysician: To the best of my kn niner: On the basis of examin					

29d. Date signed (Month, Day, Year)

(or as a consequence of):

Registrar DHMH 17 Rev 1/2001

State

32. Registrar's Signature

person who completed cause of death (Item 23a) (Type, Print)

Kaufmann, MD 300 West Ninth Street, Frederick, MD 21701

29c. License number

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 001 36784 Certificate of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Year **Physician** Sue Stephenson Flaherty 31, 10:00 a^M Oct. 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 736 Trenton Avenue Anne Arundel Severna Park If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours Days 1 ☐ M 25 F 68 132-28-6593 Yrs. Director Apr. 2, 1936 NY Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or Items 23s or 28s-f show the Medical Examinar must be notified at 1 ☐ Yes 21 No Director Anne Arundel Severna Park 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21146 USA 736 Trenton Avenue Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married White 1 ☐ Yes 2 X No Specify: Completed by 3 ☐ Widowed 4 ☑ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) High School Teaching Asst. Education 4 treumatic event, 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be s 1 and 2 should be fi f Health and Mental H item 27 is marked otl Jean Stanton Everett Wood Stephenson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 09 581 Highbank Road, Severna Park, MD Jean Converse/Daughter permit. Pages 1 and Department of Health Important: If item 27 any injury or other tonce. other 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State Nov. 2, 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Baltimore, MD Metro Crematory 1 4 ☐ Donation 5 ☐ Other (Specify) 2004 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Barranco & Sons, Barranco & Sons, P.A. Severna Park Funeral Home 495 Gov. Ritchie Hwy, Severna Park, MD 21146 23a. P.m.f. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, nock, or heart failure. List only one cause on each line. Immediate Cause (Final Due to (or as a consequence of): **Physician** disease or condition resulting in death) /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): physician Completed by Physician/Medical as IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death use 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? ō Month Year 4 Pregnant at time of death 5 Other (specify) signed by the a 1 ☐ Yes 2 ☑ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 No 3 Probably 4 Unknown Yes been 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No page 2 1 Yes director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 1 🗌 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Pesidence 6 ☐ Other (Specify) this funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Death 28b. Time of 28d. Describe how injury occurred 27. Manne After atural 5 Pending after death. 1 ☐ Yes 2 ☐ No 2 Accident investigation the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 | Homicide within 24 hours a 1 ritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier pleted cause of death (Item 23a) (Type, Print) 30. Name and address of person who comy 13456 31. Date filed (Month istrar's Signature Year) State Registrar

DHMH 17 Rev 1/2001

filed within 72 hours after death

The law requires that the death certificate be executed

P.O. Box 68760.

Division of Vital Records,

or Attending Physicien:

Baltimore, Maryland 21215-0036

DHMH 17 Rev 1/2001

Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

			For State Registrar	State	of Marylar	•	artment o			and M		-	2004	36786
ı			Decedent's Name (First, Midd	le, Last)							2. Date of Dea	ath	Year	3. Time of Death
	Physicia /Medic		Karen A.Gick								lovember	r 3,	2004	12:05 P M
Š	Examin	er	4a. Facility Name (If not institution 10511 Beechwood)		umber)		4b. City, Tov			of Death			County of Deal	th
F	Funeral		5. Social Security Number	6 Sex	7. Age (In yrs.	last birthday)	If Under 1 Y	/ear	If Under 2	24 Hrs.	8. Date of Birt			thplace (State or Foreign
	Director		215-48-0722	1□M 20 X F	58	Yrs.	Months	ays	Hours	Min.	June 26	, 19	46 Wash	thplace (State or Foreign ountry) nington DC
	land ow		Usual Residence of Decedent 10a. State 10b. Count	,	10c. Ci	ty, Town or Lo	ocation							10d. Inside City Limits
	a-f sh	tor	Maryland Cha	rles		Waldor	rf							1 ☐ Yes 2 ☐ No
	ours after death with the Marylar ral', or Items 23a or 28a-f show Exp. off. er r. wat be notified at	Director	10e. Street and Number				10f. Zip Co		0.1			10g. Citi	zen of What Co	ountry?
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Ω	or item	Funeral	1 □ Never Married 2 🛣 Ma	Armed f ried 1 ☐ Yes	Forces? 2 X No		If Yes, specify 1 ☐ Yes 2 💢		Specify:	, Puèrto	cify Yes or No Rican, etc.)		Black, Whit	te, etc.
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na	be file Ital Hy Id oth event	Be	17. Father's Name (First, Middle								<i>(First, Middle,</i> Adriani	Maiden	Sumame)	
<u> </u>		ဥ	Joseph P. Mers			19b. Mailir	na Address (S	treet a				r, City o	r Town, State, 2	Zip Code)
Baltimore, Maryland	s 1 and 2 should t Health and Mer item 27 is marke other traumatic		Robert L. Gick		ıd								MD 2060	
ore,	es 1 a of Hea of Hea fitem r othe	1 2	20a. Method of Disposition 1 ☐ Burial 2 🛣 Cremation		n State	Place of Dispo cemetery, crei	osition (Name matory or other	of or place	9)	D	ate	20c. Lo	cation - City or	Town, State
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			23a. Part . Enter the disease, of shock, or heart failure. Lis	r complications that	t caused the dea	th. Do not en	ter the mode o	of dying	such as	cardiac c	r respiratory ar	rest,	05	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	\mathcal{P}_{r}		DX- R	erla	1	Car	cer	- 16	54.	1	Onset and Death
	/Medical Examiner		resulting in death)	Due t	o (or as a consec						and	liu	0	
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	cuted nd ransit	Examin	that initiated events	C										
760,	ate be executed hysiclan and he burial-translt		resulting in death) Last	Due t	o (or as a consec	quence of):								
687	ficate I physics the b	edical		d										
Box	death certificat e attending phy d for use as th	M/M	IF FEMALE: 23b. Was decedent pregnant		outcome of pregn		∃Ectopic pregr	nancv					23d. Date of del	
о. В	0 0 0	Physician/Med	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown-		gnant at time of		Other (speci						Month	Day Year
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		Соп									perfo 1 □ Yes	rmed? No	death? 1 ☐ Yes	2 □ No
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ion	Attending ir death. ector: After by the funer	atio	2 1/100/00/10	tigation	onii, Day 16ai)	Injury	М		/es 2□t					
Division of	l or Attence after death Director:	Certification:	3 Suicíde 6 Coule 4 Homícíde deter	minad 200. Fld	ce of Injury · At h Iding, etc. (Speci	nome, farm, st ify)	reet, factory, o	office			28f. Location (S City or Tox			ural Route Number,
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,	LIX.		30. Name and address of person	n who completed ca	use of death (Ite	m 23a) (Tvpe	Print)	4	1	> ,			()	
d	DB7		Dr. Krishan M	athur, 35	00 01d	Washing	gton Ro	ad	#102	, Wa	ldorf,	MD 2	0602	
	Sta Regist		31. Date filed (Month, Day, Yea	³² 5 2004	. Resistrar's Sign	ature	bouts							

ij ^S E	E. GAITE	HEF	For	State of M	aryland / Dep	artment of H				36797
ar	1		1 - State 1 - American American American Middle, Last, 1. Decedent's Name (First, Middle, Last)		Ce	runcate or i	Jealii	2. Date of Dea		36787
	Physici /Medi		John E. Gaith	er-El				OCT.	30 ^{Day} 2004 ^{Year}	1800 Р м
	Examir		4a. Facility Name (If not institution, give			4b. City, Town, or		ath	4c. County of Death	1
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	Funeral Director		5. Social Security Number 6. Sec. 1X	7. Ag	e (In yrs. last birthday, 42 Yrs.	Months Days	If Under 24 Hr Hours Mir	1. (Month, Day	(, Year) Coul	place (State or Foreign
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	the M	Director	10e, Street and Number			10f. Zip Code	shington		105 China of What Court	fX Yes 2 □ No
	within 72 hours after death with the Maryland ane. than "neturel; or Items 23a or 28a-f show the Medical Ever the Frinst Le rolling at		3109 - 13th S	t., N.E.		Toi. Zip Code	2001		log. Citizen of What Cou United	
	ltems 2	Funeral	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S. 13.	Was Decedent of Hi If Yes, specify Cuba	ispanic Origin? (Specify Yes or No-	14. Race - Americ Black, White,	
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aryl	d 2 should be the and Mental I is marked or traumatic ever	2	19a. Informant's Name/Relationship (Ty)			ng Address (Street a	and Number or F		s Brown , City or Town, State, Zip	Code)
ĭ,	12 d 7 m		Tyrone Gaither-	E1 / Fath		09 - 13th				,
Baltimore, Maryland 21215-0036	S = = 0		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ R	emoval from State	20b. Place of Dispo cemetery, cre	osition (Name of matory or other place	9)	Date	20c. Location - City or To	own, State
ţ	t. Pag rtment rtant: njury		4 Donation 5 Other (Specify)		Quantico				Triangle,	VA
Bal	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service License	Leura	111	2. Name and Addres 4001 Be			uneral Home Wash., DC 2	0019
Г			23a. Part1/Enter the disease, or complishock, or heart failure. List only on	cations that caused e cause on each li	the death. Do not en	er the mode of dying	g, such as cardia	ac or respiratory arr	est,	Approximate Interval Between
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8760,	be exician a		resulting in deathy Last	Due to (or as	a consequence of):					
687	ficate p phys ts the	edical	\ d							
X	death certificate be executed e attending physician and nd for use as the burial-transit	M/W	200. Was decedent pregnant	3c. If yes, outcome		Ectopic pregnancy			23d. Date of delive	ry
.O.	the deal y the att	Physician/Me	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	4☐Pregnant at 9☐ Unknown		Other (specify)			Month	Day Year
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OU	Attending I r death. octor: After by the funer	tlon	1 Natural 5 Pending 2 Accident investigation	(Month, Day	Year) Injury	Work	es 2 No		w injury occurred	
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	To the Hospital or At within 24 hours after or To the Funeral Direct completely filled in by	Medical	29a. Certifier 1 Certifying Phys (Check only one) 2 Medical Exemin	ician: To the best of er: On the basis of and manner sta	examination and/or in	n occurred at the time vestigation, in my op	e, date and place inion, death occ	e, and due to the ca	iuse(s) and manner as st ate and place, and due to	ated
	To the within To the comple	FMe	29b. Signature and title of certifier	(0/		29c. License		25	9d. Date signed (Month, I	Day, Year)
	MA		Mouste 1	re The	llun	0.0	.M.E		OCT. 31,	2004
R	(2)		30. Name and address of person who con	mpleted cause of d			Baltimo	re, Maryl	and 21201	
	Sta	-	31. Date filed (Month, Day, Year)	32 Registra	ar's Signature					
	Registr	ar	NOV 0 8 2004	Mayre	, K Am	W.				

			State of Maryland / Department of Health and	Mental Hygi	ene _	
			1 - State Certificate of Death		g. No. 200	
	Physicia	n	1. Decedent's Name (First, Middle, Last)	2. Date of Death	Day Year	3. Time of Death
	/Medic	al	Harold Don Gipson	October		
	Examin	er	4a. Facility Name (If not institution, give street and number) Anne Arundel Medical Center 4b. City, Town, or Location of Deal Annapol		4c. County of Dea	
			Anne Arundel Medical Center Annapol 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs			
	Funeral Director	į	1458_82_2749 Usual Residence of Decedent			irthplace (State or Foreign Country) CEXAS
	iand ow		10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
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	r 282	Director	10e. Street and Number 10f. Zip Code	10	g. Citizen of What C	ountry?
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	ems ems	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (5 If Yes, specify Cuban, Mexican, Puer	Specify Yes or No- to Rican, etc.)	14. Race - Am Black, Wh	
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Maryland 21215-0036	within 72 hours after ene. than "natural", or Ite	Completed	15. Decedent's Education (Specify only highest grade completed) [Give kind of work done during most of woll life. DO NOT use retired)	orking	6b. Kind of Busines:	s/Industry
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	d 2 th a tra		Wondy Worny / daughter 2374 Sandy Walk Way (Monton M	D 21113	
re,	s 1 and 3 if Health item 27 other tr		Wendy Wozny/ daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cametery, crematory or other place)	Date 2	0c. Location - City o	r Town, State
Ē	Page ent o nt: If ry or		1 Surial 2 Cremation 3 Hemoval from State	4 2004	Grand Pr	airie, TX
Baltimore,	permit. Pages 1 an Department of Heal Important: If item 2 any injury or other ance.					cal Home, Inc
m	Depar Depar Impo any in		I Scott Hamenadu 147 Duke of Glouce			
	Physician /Medical Examiner	her	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardia shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying. Due to (or as a consequence of): Due to (or as a consequence of):	c or respiratory arres	st,	Approximate Interval Between Onset and Death > \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \
68760,	ificate be executed g physician and as the burial-transit	edical Examiner	Cause (Disease or injury that initiated events resulting in death) Last C			
.O. Box	that the death certifica ed by the attending ph detached for use as th	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify)		23d. Date of de Month	elivery Day Year
<u>a</u>	The law requires that the ste has been signed by the bage 2 should be detache	by Pł	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did toba	acco use contribute	to the cause of death?
rds	w requires that been signed t should be det	d be	Hypertension	1 🗆 Yes	2 □ No 3 □ F	Probably 4 Monknown
Records,	s bee	Completed	Paroxysmal Atrial Fibrillation	24a. Was an	24b. Were a	autopsy findings available
Re	The taw ate has page 2 :	E	Hyperlipidemia	autopsy perform	ed? death?	
Vital		O	25. Was case referred to medical 26. Place of De	ath (Check only one,		
>	S 5	To B	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing I	Home 5 ☐ Residen	nce 6 Other (Sp.	ecify)
n of			27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Date of Injury 28b. Time of 28c. Injury at Work?	28d. Describe how	v injury occurred	
Division	Attending ir death. ector: After by the fune	Certification:	2 Accident investigation M 1 Yes 2 No			
Ξ̈́	l or Attenu after deatl Director: i in by the	rtific	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Stre City or Town,	eet and Number or F State)	Rural Route Number,
Ω	urs af			<u>V</u>		
	To the Hospital or At within 24 hours after or To the Funeral Direct completely filled in by	edical	29a. Certifier (Check only one) 29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.	e, and due to the cau urred at the time, dat	use(s) and manner a te and place, and du	is stated. ie to the cause(s)
	o the	Me	29b. Signature and title of certifier 29c. License number	290	d. Date signed (Mor	nth, Day, Year)
	->-0		1 Total Such Die HC052843		11-1-0	74
			30. Name and address of person who completed cause of death (Item 23a) (Type, Print)		^	
			Dr. Peter Swaby 4000 Mitcheleville Rd, S	wite 84	55 Bom	9150S BM 31
	Sta	te	31. Date filed (Month, Day, Year) 32. Resistrar's Signature			
	Registi	ar	NOV - 3 2004 1000 15 1000			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** October 30, 2004 Robert L. Higginbotham 4:45 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Crescent Cities Center Riverdale Prince Georges 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
July 28, Funeral 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Days Hours 10XM 2□ F 89 Yrs. Director 180-12-5089 1915 Pennsylvania Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location Item 27 is marked other then "natural", or Items 23a or 28a-f ehow other traumatic event, the <u>Medical Evant for marked redified at</u> 10d. Inside City Limits Director 1 Yes 2 □ No D.C. N/A Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? With 20011 427 Buchanan Street, N.W. United States death by Funeral 12. Was Decedent Ever in U.S Armed Forces? 1.0.2 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 XYes 2 No 1937− If Yes, Give Year or Dates: 1960 2 should be filed within 72 hours after a and Mental Hygiene. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo **Black** 3 XWidowed 4 ☐ Divorced Specify: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Housing Inspector D.C. Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Bessie C. Lee Robert Higginbotham 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 st Department of Health and Important: if Item 27 is n any injuryor other traun Peter K. Higginbotham (son) 2300 Irving Street, S.E., Washington, D.C. 20020 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State `4 ☐ Donation 5 ☐ Other (Specify) 11/17/04 Arlington National Arlington, VA 22. Name and Address of FacilityMcGuire Funeral Service 21. Signature of Funeral Service Licenses Mampson 7400 Georgia Ave. N.W., Washington, D.C. 20012 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Arteriosclerotic Cardiovascular Disease disease or condition resulting in death) years /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. End of darping Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner as the burial-transit The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): attending physician Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4□Pregnant at time of death 5 Other (specify) P.0. 9 Unknown 9 Unknown ģ signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ Diabetic Mellitus, Dementia Completed 1 Yes 2 No 3 Probably 4 XUnknown 24b. Were autopsy findings available prior to completion of cause of death? Pulmonary hypertension Hypothyroid 24a. Was an cate has autopsy performed Peripheral Vascular disease 1 ☐ Yes 2 ☐ No 1 Tes 2 🗶 No Hospital or Attanding Physician: 25. Was case referred to medical 26. Place of Death (Check only one) examiner's Other: Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2X No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred After 1 X Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident Diractor: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 24 hours a 1 Xcertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. npletely (Check only one) To the within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D01852 November 2, 2004 1041 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Paul A. DeVore, M.D. 4203 Queensbury Road, Hyattsville, MD

DHMH 17 Rev 1/2001

Registrar

31. Date filed (Month, Day, Year)

NOV 04 2004

32. Registrar's Signature

			1 - For State Registrar	State of Marylar	nd / Depa		Health and		ene 💍	04 36791
	Physici	20	1. Decedent's Name (First, Middle, Last)				2. Date of Death Month		3. Time of Death
	/Medic		DA	VID HOWAR'	TH			201	31 2	001 0930 A M
	Examir	er,	4a. Facility Name (If not institution, give Malcolm Grow	MA III	enter	4b. City, Town	n, or Location of Dea SPANGS	th	4c. County of	e Georges
	Funeral Director		022-30-0244	7. Age (In yrs.	last birthday) Yrs.	If Under 1 Ye Months Day		. (Month, Day,	Year) 1938	9. Birthplace (State or Foreign Country) RHODE ISLAND
	and w		Usual Residence of Decedent 10a. State 10b. County	10c. Ci	ty, Town or Lo	ocation				10d. Inside City Limits
	Maryl 4 sho	ō	MD. PRINCE G				•			1 ☐ Yes 2 ☐ No
	1 the	Director	10e. Street and Number	EORGES	N.	10f. Zip Code		10	g. Citizen of Wh	21
	h with	O IE	5732 CRESTWO	OD PI.			20737			S.A.
	Items 2	ner	11. Marital Status	12. Was Decedent Ever in U Armed Forces?	l.S. 13.		of Hispanic Origin? (Suban, Mexican, Puer	Specify Yes or No-	14. Race	American Indian,
21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-1 show other traumatic svent, the Madical Exeminer must be notified at	by Funeral	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	1 Yes 2 No 1950 If Yes, Give Year or Dates: 19	6-	1 ☐ Yes 2 🏋 N		no rican, etc.)	Specify:	White, etc. WHITE
5-0	72 h	Completed	15. Decedent's Edu (Specify only highest grad		16a. Deced	dent's Usual Occ	cupation ne during most of wo	odkina 1	6b. Kind of Busi	
121	within ene. then o	mp	Elementary/Secondary (0-12)	College (1-4or 5+)	lite.	DO NOT use ret	ired)	9		
	Hygie Hygie other t		17. Father's Name (First, Middle, Last)	2		U. S.	AIRFORCE	me (First, Middle, M		ENSE
Maryland	d be sold o	o Be	SAMUEL	HOWARTH			To. Mother's Na			
Ž	should and Men is marke	ပ္	19a. Informant's Name/Relationship (T)		19b. Mailir	ng Address /Stre	net and Number or B	ESTHER ural Route Number,		NOWN
Ma	and 2 : ealth ar n 27 is		LUZVIMINDA HOWAI					RIVERDALE		
re,	s 1 and 3 Health itsm 27 other tr		20a. Method of Disposition	20b. F	Place of Dispo	sition (Name of				ty or Town, Stete
E	Pages nent of int: If it		1 Burial 2 □ Cremation 3 □ F 1 □ Donation 5 □ Other (Specify)	temoval from State	-		. CEM. 11	_16_2004	ADI TNO	ron, va.
Baltimore,	permit. Pages Department of t Important: If Its eny injury or of		21. Signature of Funeral Service Licens	00 (1) (A)	CE CE	. Name and Add	ress of Facility FUNERAL H	OME & CRE	MATORTU	M.P.A.
			23a. Part1. Enter the disease, or complete the complete t	ications that caused the deat		SO1 CLEV er the mode of d	VELAND AVE	RIVERD	ALE, MD	20737 Approximate
	Physician /Medical		shock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	Due to (or as a conseq	ory f	ailure		, , , , , , , , , , , , , , , , , , , ,		Interval Between onset and Death
	Examiner			() P ()	deriogory.					20 years
		Jer	Sequentially list conditions if any, leading to immediate cause. Enter Underlying	ue to (or as a conseq	uence of):					00 1/2000
	te be executed ysician and ie burial-transit	Examiner	Cause (Disease or injury that initiated events							
o O	e exe ian a urial-t	EX	resulting in death) Last	Due to (or as a conseq	uence of):					1
8760,		Ilcai		1						
x 68	entific fing p	Mec	IF FEMALE:						1-22	
.O. Box	The law requires that the death certificate be executed tie has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregnation 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d 9 ☐ Unknown	Ideath 3 🗌	Ectopic pregnar Other (specify)			23d. Date of Month	
٥.	that the ded by detac	Ph	Part II. Other significant conditions con	ntributing to death but not res	ulting in the un	iderlying cause o	siven in Part I.	23e. Did toba	cco use contribu	ite to the cause of death?
ords,	w requires that been signed I should be det	ted by	infection	4 j						☐ Probably 4 Munknown
Record	The law cate has b page 2 st	Completed	hypercoaguat	ole Status	<u>}</u>			24a. Was an autopsy performe	d? prio	re autopsy findings available r to completion of cause of th? Yes 25100
Vita	ysician: This certificate director, pag	Be	25. Was case referred to medical examiner?				26. Place of Dea	ath (Check only one)	100	103 2,23110
<u>~</u>	Physic this ce al dire	2	1 ☐ Yes 2 No	lospital:	ER/Outpatient	3 □ DOA C	Other: 4 Nursing H	lome 5 Residen	e 6 Other	(Specify)
_	ding Ph h. After thi funeral	ö	27. Manner of Death 1 X Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Inj	ury at ork?	28d. Describe how	injury occurred	
sio	tendi leath. tor: A the fu	cat	2 Accident investigation 3 Suicide 6 Could not be	,		M 1[Yes 2 No			
Division of	Hospital or Attendi Z4 hours after death. Funeral Director: A etely filled in by the fu	Certification;	4 Homicide determined	28e. Place of Injury · At he building, etc. (Specify	ome, farm, stre	est, factory, office	8	28f. Location (Stree City or Town,	et and Number (State)	or Rural Route Number,
	To the Hospital or Attending Physician: within 24 hours after death as a fire death or To the Funeral Director: After this certified completely filled in by the funeral director;	edical	29a. Certifier (Check only one) 2 Medical Examin	sician: To the best of my kno ner: On the basis of examinal and manner stated.	wledge, death tion and/or inv	occurred at the estigation, in my	time, date and place opinion, death occu	, and due to the causered at the time, date	se(s) and manne and place, and	er as stated. due to the cause(s)
	To the Within 2 To the complet	Me	29b. Signature and title of certifier			29c. Licei	nse number	290	. Date signed (A	Nonth, Day, Year)
	2+1		> Promone			N.M	# 97-	319 (ict 3	1,2004
•	2	>	30. Name and address of person who co	mpleted cause of death (Item	23а) (Туре, Р				1	20107
	117		tatrick B M	onahans	nD.M	ai 10	50 W Pe	cimeter B	d Andr	PWS AFB MD
	Sta Registra		31. Date filed (Month, Day, Year)	32. Registrar's Signa	ture /4	land	1,			

DHMH 17 Rev 1/2001

			1 - For Stata Registrar	State of Maryla		artment of H			ene	
	Pĥysici	an	1. Decedent's Name (First, Middle,					2. Date of Death Month	Day Year	3 Jimesof Pearly
	/Media				Hastir			Novemb		
?	Examir	ier	4a. Facility Name (If not institution,	· ·			r Location of Death		4c. County of Dea	
			5182 Wastega 5. Social Security Number		. last birthday)	Parson	ISDURG If Under 24 Hrs.	2. Date of Righ	Wicomio	
	Funeral Director		554-30-1078 Usual Residence of Decedent	1⊠M 2□F 77	Yrs.	Months Days	Hours Min.	8. Date of Birth Month Day 8/22/1	927 U1	rthplace (State or Foreign ountry) Can
	and and		10a. State 10b. County	10c. C	ity, Town or Lo	ocation				10d. Inside City Limits
	ath with the Marylan 23a or 28a-f ehow ust be motified at	ō	Maryland Wi	comico	Parc	onsburg	r			1 □Yes 2 No
	28a-	rec	10e. Street and Number	COMICO	rars	10f. Zip Code)	10	g. Citizen of What C	ountry?
	with Sa or	۵	5182 Wastega	te Road		21849			USA	,·
	ns 23	era	11. Marital Status	12. Was Decedent Ever in U	J.S. 13.			ecify Yes or No-	14. Race - Am	erican Indian,
21215-0036	4 within 72 hours atter death with the Maryland Jiene. r then "natural", or Items 23a or 28a-f ehow Ite Medical Examiner must be rediffed at	by Funeral Director	1 ☐ Never Married 2 ☐ Marrie 3 ☐ Widowed 4 ☐ Divorced	Armed Forces?	0-71	If Yes, specify Cuba 1 □ Yes 21 <mark>X</mark> No	lispanic Origin? (Spi an, Mexican, Puerto Specify:	Rican, etc.)	Black, Wh	white
ğ	2 hou	ted	15. Decedent's	Education	16a, Dece	dent's Usual Occup	ation	1	6b. Kind of Business	s/Industry
215	within 7 ene. then "n	ple	(Specify only highest		(Give	kind of work done of DO NOT use retired	during most of work. d)	ing		
21	d withir giene. ir then	Completed	Elementary/Secondary (0-12)	College (1-4or 5+) 4+	Care	er Mili	tary		U.S. Arn	ıy
ğ	be filed ntal Hygie ad othar evant, II	a)	17. Father's Name (First, Middle, La	· ·			18. Mother's Name	e (First, Middle, Ma		
Maryland	Mer Mer Brks etic	To B	Harold 19a. Informant's Name/Relationshi	Hastings	10h Mailir	a Address (Street	Veda	Lucill	e Berto	
Ma	" m m =								•	
a	Pages 1 and 2 ment of Health a ant: If itam 27 Is ury or othar tra		Debra D. Hixo 20a. Method of Disposition	20b.	9319 Place of Dispo	Guy Wa sition (Name of	ra Ra.	Parsons	buarg, MI Oc. Location - City o	21849
٥			1 🗷 Burial 2 ☐ Cremation 🤇	3 □Removal from State W:	rcomic	Commentor	/#/ ~ T '			
ŧΪ	t. Pa rtmer rtant rjury		`4 □Donation 5 □ Other (Spe		Park				Salisbur	
Baltimore,	permit. Page Department of Important: If any injury or		Signature of Funeral Service Li		Ħ	OTIOWAY	s Fünera	l Home	Professi	onal Assoc
	4020		David St. you	rpor CFSP] 5	OI Snow	HILL RO	d.,Sali	sbury,MD	21804
П			23a. Part1. Enter the disease, or c shock, or heart failure. List or	omblications that caused the dea nly one cause on each line.	th. Do not ent	er the mode of dyin	ig, such as cardiac o	or respiratory arres	st,	Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition	- ATHERO.	CLER	COTIC	HEAR	T DIST	EASE	YEARS
	/Medical		resulting in death)	Due to (or as a conse						
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ó	e exe ian a urial-		resulting in death) Last	Due to (or as a conse	quence of):					
8760,	cate be exc physician a the burial	ical	· ·	d						
9	ng ph	Med	IF FEMALE:							
Вох	death certiticate be executed e attending physician and nd for use as the burial-transit	Physiclan/M	23b. Was decedent pregnant	23c. If yes, outcome of pregr 1 ☐ Live birth 2 ☐ Fet		Ectopic pregnancy	,		23d. Date of de	,
	ed for	sicl	in the past 12 months? 1 □ Yes 2 □ No	4□Pregnant at time of		Other (specify)			Month	Day Year
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	es that igned to be det	by	Part II. Other significant condition	s contributing to death but not re	sulting in the u	nderlying cause give	en in Part I.	23e. Did toba		o the cause of death?
ord	w requir been si should	ted						1 ☐ Yes	2 2 No 3 □ P	robably 4 □Unknown
Records,	2 5 8	ompleted						24a. Was an autopsy		utopsy findings available completion of cause of
	The la ate ha page 2	E O						performe	ad? death?	
Vital	icien: T certiticat rector, p	e C	25. Was case referred to medical				26. Place of Death	(Check only one)		
>	Physicien: this certitic ral director,	OB	examiner?	Hospital: 1 ☐ Inpatient 2 ☐] ER/Outpatier	nt 3 DOA Othe	05		ce 6 ☐Other (Spe	ecify)
of	g Ph er th eral	n: T	27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of	28c. Injun Worl	Table 1	28d. Describe how		
Division	Attanding Ir death. actor: Alter by the tuner.	Certification:	Natural 5 Pending 2 Accident investiga		Injury		Yes 2 □ No			
Vis	of or Attandatter death Diractor:	ific	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	286. Place of Injury - At I	nome, farm, str	eet, factory, office		28f. Location (Stre City or Town,	et and Number or R	ural Route Number,
ā	spital or ours atte neral Dira	Sert	Thomas -	building, etc. (Spec	1197			City of Town,	State)	
	a Hospital 24 hours a e Funeral l letely tilled		29a. Certifying	Physician: To the best of my kn	owledge, death	occurred at the tim	ne, date and place,	and due to the cau	ise(s) and manner a	s stated.
	To the Hosp within 24 ho To the Fund completely t	edical	(Check only 2 Medical E	xaminar: On the basis of examin and manner stated.	ation and/or in	vestigation, in my or	pinion, death occurr	ed at the time, dat	e and place, and du	e to the cause(s)
	To tha within 2 To the comple	Me	29b. Signature and title of certifier	Λο Λ		29c. License			d. Date signed (Mon	
	7)	MOHAN B	HAT M	0 05	5006	Ν	OVENIBE	R 3 2004
	18)		30. Name and address of person w	ho completed cause of death (Ite	m 23a) (Type,	Print)		- 1,7		
e ga	11		614-B EA	ISTERN SHO	RE DA	RIVE J	ALISBU	RY 1	10 210	F04
	Sta	ite	31. Date filed (Month, Day, Year)	ho completed cause of death (Ite STERN SHC 4 2004 32. Registrar's Sign	ature /	1	V. 0	/		
*	Regist	rar	NOV 0	± 2004		ppou				

04-070		ors		se Type or	Print in E of Marylan							_egible		
RPD			1 - State Registrar		, marytan		tificate c		X11G 19		Reg. No	nnı	36700	
	Physici /Medi		1. Decedent's Name (First, Middle Terrel Le		sell	Ho11	and			2. Date of Dead Month OCTOBE		, 2002	3. Time of Death 0214 A M	
	Examir		4a. Facility Name (If not institution Prince George 's	, give street and nu S Hospita	mber) 1 Center	-	4b. City, Town Chever	-			Pr		ath George's	
	Funeral Director		5. Social Security Number 214-02-0045 Usual Residence of Decedent	6. Sex 1 M 2 □ F	7. Age (In yrs. 22	last birthday) Yrs.	If Under 1 Ye Months Day		24 Hrs. Min.	8. Date of Birt OCt.	, 198	2 9. B	9. Birthplace (State or Foreign Country) Maryland	
	Maryland t-f show filed at	įį	10a. State 10b. County	alvert	10c. Cit	y, Town or Lo Owin							10d. Inside City Limits 1 ☐ Yes 2 ☑ No	
	th with the 23a or 28s	ai Direc	laryland Ca 10e. Street and Number 410 Skinne		Road		10f. Zip Code	0736				en of What (Country?	
036	s 1 and 2 should be filed within 72 hours after death with the Maryland feralth and Mental Hygiene. It health and Sontal Hygiene. It health and so or 28a-f show there is a show the traumatic event, the Medical Examiner must be notified at	by Funerai	11. Marital Status 1 🛣 Never Married 2 🗆 Marr 3 🗆 Widowed 4 🗇 Divorced	Armed Fo	ve	ı	Vas Decedent of Yes, specify C		gin? (Spe , Puerto	ecify Yes or No- Rican, etc.)		4. Race - An Black, Wh Specify: B1		
Baltimore, Maryland 21215-0036	i within 72 ho lene. r than "natur ine Medical	Be Completed	15. Deceden (Specify only highes Elementary/Secondary (0-12) 1 2	t's Education st grade completed) College (**	1-4or 5+)		ent's Usual Ock kind of work do NOT use ret			ing		d of Busines		
/land?	12 should be filed within h and Mental Hygiene. 7 Is marked other than " rraumatic evant, the Mea	To Be C	17. Father's Name (First, Middle, Russell	Last)	Ho1	land,		Sy1v	/ia	(First, Middle, Blak	ce	Mors		
, Mar	ss 1 and 2 sho of Health and itam 27 Is ma		19a. Informant's Name/Relations Russell Holla			19b. Mailin	g Address (Street) . Box	97 Ov	ໄປ ^{Rug} S ving	Route Number kinner s. MD	r, City or S T 207	Town, State urn R 36	Zip Code) .d.	
timore	permit. Pages 1 Deparfment of H Important: If ita any injury or ott		20a. Method of Disposition 1	pecify)	State Ca	race of Dispo- emetery, crem rter	sition (Name of SUMC the C	em. 1	1/5	0 / 0 4	Fri	endsh	r Town, State .ip, MD	
Bal	permi Depar Impos any ir		21. Signature of Funeral Service Bladyp G	Licensee	ll	1 4	Name and Add	es Bea	Se ch	well F Rd. Pr	une	ral H e Fre	ome d.,MD20678	
	Pnysician /Medical Examiner		23a. Part1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)	only one cause on e	caused the death each line.	de I	r the mode of o	tying, such as	cardiac o	r respiratory ar	rest,		Approximate Interval Between Onset and Death	
	ufed d snsif	Examiner	Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events	b. Due to	(or as a consequ	uence of):								
,8760,	rificate be executed g physician and as the burial transit		resulting in death) Last	Due to	(or as a consequ	uence of):								
P.O. Box 68760	Attanding Physician: The law requires that the death certificate be death. octor: After this certificate has been signed by the attending physicit by the funeral director, page 2 should be detached for use as the bu	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 ☐Live b	tcome of pregna birth 2 Fetal pant at time of de own	death 3	Ectopic pregnar Other (specify)				23	ld. Date of de Month	elivery Day Year	
rds, P	v requires fhat been signed b should be deta	by	Part II. Other significant condition	ns contributing to de	eath but not resu	ulting in the un	derlying cause	given in Part I.		23e. Did to	14		to the cause of death?	
l Reco	The law requate has been page 2 shoul	Completed								24a. Was a autops perform	sy	24b. Were a prior to death?	utopsy findings available completion of cause of	
Vita	iician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	Hospital:				\4L		(Check only or				
of	g Physer this eral di	7: To	1 X Yes 2 No 27. Manner of Death	28a. Date	of Injury	ER/Outpatient 28b. Time of	3 DOA 28c. In	4 LI NUI		ne 5 🗆 Reside 28d. Describe he			ocity) river of motor	
Division of Vital Records,	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate h completely filled in by the funeral director, page	Medical Certification:	1 Natural 5 Pendin 2 Accident investig 3 Suicide 6 Could r 4 Homicide determ	not be ined 28e. Place buildi	th, Day Year) O I of Injury - At hong, etc. (Specify	me, farm, stre	4 M 1	☐ Yes 2 🔼 N	lo i	enck	INVEN	ed in Number or F 5/13 49	CONTISION OUT A POUT OF THE P	
	a Hospl 24 hou a Funar etely fill	dicai	29a. Certifier (Check only one) Certifyin 2 Medical	g Physician: To the Examiner: On the ba	best of my know asis of examinat ner stated.	wledge, death tion and/or inv	occurred at the estigation, in my	time, date and y opinion, deat	l place, a	and due to the co	ause(s) a late and p	nd manner	s stated	
	To th within To th compl	Me	29b. Signature and title of certifier	. /	101)		29c. Lice	nse number		2	9d. Date	signed (Mon	th, Day, Year)	
			30. Name and address of person	but NULL i K		23a) (Type F		.M.E.		C	Octob	er 31,	, 2004	
	j0		Pamela E. S	outhall, m	10	1		Street	, Bá	altimore	e, Ma	ryland	1 21201	
	Sta Registi		31. Dåte filed (Month, Day, Year)	0 3 2004)	egistrats Signal	ture K	Louis	2						

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) October 31 2004 10:55A **Physician** Shirley Holland /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth **Examiner** Anne Arundel Arnold 845 Mago Vista Rd. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** 1□ M 2√2 F Director 64 29 1940 D.C July 219-40-5604 Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County show ral', or Items 23a or 28a-f shov Examinar must be notified at 1 □Xes 2 □ No Maryland Anne Arundel Arnold 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Pages 1 and 2 should be filed within 72 hours after death with 845 Mago Vista Road 21012 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-ff Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 ☐ Yes 2 📉 No If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: Completed by 3 Widowed 4 Divorced Black Year or Dates: natural', permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medical ance. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Coflege (1-4or 5+) 12th Proofer Banking 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be 2 <u>Lillian Green</u> Matthew Green 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 845 Magg Vista Rd. Arnold, Maryland 21012 Thomas Holland (Husband) 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other of cometery, crematory or other place)

Lakemont Memorial 1 Burial 2 ☐ Cremation 3 ☐ Removal from State and Address of Facility

Reese & Sons Mortuary, P.A.

Wiest St. Annabolis, Mc. 21.01

Approximate Interval Between Onset and Death * 4 ☐ Donation 5 ☐ Other (Specify) Davidsonville, Md. Gardens 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Zarry A. Reese Mooy83 Wm. Reese & Sons Moritude 821 West St. Annabolis, 23a. Parti. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. fmmediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) use as the burial-Box 68760. attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year for in the past 12 months? 1 ☐ Yes 2 No 4□Pregnant at time of death 5 Other (specify) signed by the a P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part ff. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. ģ 1 ☐ Yes 2 No 3 Probably 4 Unknown Be Completed peed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an has autopsy performed? this certificate 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home Residence 6 Other (Specify) Hospital: 1 ☐ Yes ~2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After t Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: All completely filled in by the fu 2 Accident 6 Could not be determined 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of contrier 29c. License_number 3b. Name and address of person who completed cause of death (Item 23a) (Type, Print) 0 estrar's Signature 31. Date filed (Month, Day, Year) 32. Re State Registrar

			State of Maryland / Department of Health and M 1- State Registrer Certificate of Death	ental Hygie	711114	36794
	Physici		1. Decedent's Name (First, Middle, Last) Freedman R. Holland	2. Date of Death	Day Year	3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death HERTE ARUSTORY HOSPITAL GLEA BURY	1100	4c. County of Death	YRUNIDEL
	Funeral Director		1 StM 2 F Months Days Hours Min.	8. Date of Birth (Month, Day, Ye May 6 19	ar) Cour	place (State or Foreign ptry) 1and
	ne Maryland Ba-f show	Director	10a. State 10b. County 10c. City, Town or Location Maryland Anne Arundel Glen Burnie			0d. Inside City Limits 1 ∑Yes 2 ☐ No
	h with th		10e. Street and Number 413 Old Stage Road Apt. F 21061	10g.	Citizen of What Cour	ntry?
920	72 hours after death with the Maryland natural; or items 23s or 28s-f show dical Examinar must be notified at	by Funerai	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No Specify: 1 Yes 2 No Specify:	ecify Yes or No- Rican, etc.)	14. Race - Americ Black, White,	
21215-0036	within ane. than "	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 1 2 th 16a. Decedent's Usual Occupation (Give kind of work done during most of work) ife. DO NOT use retired) Self Employed	ing 16b	Labore	
and 2	be filed ital Hygi id other evant, I	Be	17. Father's Name (First, Middle, Last) 18. Mother's Name	(First, Middle, Maid		<u>. T</u>
Maryland	and and is m	2	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rura		ty or Town, State, Zip	Code)
a)	of Heal of Heal if item 2 or other		Matilda Holland (Mother) 677 Donaldson Ave 20a. Method of Disposition 10 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Mother (Mother) 677 Donaldson Ave 20b. Place of Disposition (Name of cemetery, crematory or other place) St. Rest Cemetery 11		. Location - City or To [anover,	
Balti	permit. Pag Department Important: I any injury o		21. Signature of Funeral Service Licensee 22. Name and Address of Facility Wm. Reese & Son. 821 West St. An.	napolis,	ry, P.A. Md. 214	01
	Physician /Medical		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac of shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence of):			Approximate Interval Between Onset and Death
	Examiner	J.	LIVER FAILURE			
8760,	cate be executed oblysician and the burial-transit	ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): C. Due to (or as a consequence of):			
.O. Box 68	The law requires that the death certificate be executed tte has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 \(\text{Ves} \) 2 \(\text{No} \) No 9 \(\text{Unknown} \) Unknown		23d. Date of delive	ory Day Year
ecords, P.	quires that I in signed by uld be deta	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacc	co use contribute to the	
α		Completed		24a. Was an autopsy performed 1 Yes 2	24b. Were auto prior to co death? No 1 \(\text{Yes} \)	psy findings available inpletion of cause of 2 No
Vital	Physician: Th this certificate ral director, pag	To Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Impatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Hor		6 □Other (Specif	v)
on of	ding Pt After th funeral		27. Manner of Death 1 Natural 5 Pending 28a. Date of Injury (Month, Day Year) 28b. Time of Injury Work? 4 No. 2 Date	28d. Describe how in		,
Division	or Atten ifter deat Sirector: in by the	Certification;	2 Accident	28f. Location (Street City or Town, St	t and Number or Rura tate)	l Route Number,
	To the Hospital or Attend within 24 hours after deatl To the Funeral Director: completely filled in by the	Medical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and places, 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.	ed at the time, dato	and place, and due to	the cause(s)
	To t To t	Σ	29b. Signature and the of celtifier 29c. License number 29c. License number		Date signed (Month,	
			30. Name and address of person who completed cause of death (Item 23a) (Type, Print) THROTO BOTHOPHAL Printe Gleen Brun	raile M	D 210	61
	Sta Regist	ate rar	31. Date filed (Motth, Day, Year) NOV - 3 2004 32. Figistrar's Signature			

Thomas Johnson 219-46-3986

		1- For Amend Item 5 per fn G83.	7 111 - 36 Ce.	rtificate of Death	rentar myglei Reg.		_
Physic /Medi		1. Decedent's Name (First, Middle, Last) THOMAS LEE	JOHA	ISON	2. Date of Death Month 3	/ 11111	36.795 1529 M
Examir	ner	4a. Facility Name (If not institution, give street and number) PNINSUID SPRIND MODELLA	1 Central	4b. City, Town, or Location of Death SDUS6UTY		4c. County of Death	10
Funeral Director		216-116-3986 15M 20F	yrs. last birthday) 55 Yrs.	If Under 1 Year If Upder 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Ye	ar) 9. Birth	place (State or Foreign ntry)
death with the Maryland ms 23s or 28a-f show must be notified at	ctor	Usual Residence of Decedent 10a. State 10b. County 10c MD WORCESTER	c. City, Town or Lo	1			10d. Inside City Limits 1 ☐ Yes 2 📉 No
th with th	Funeral Director	10e. Street and Number 82/3 NEWARK ROA	D	10f. Zip Code 2 / 84/	10g.	Citizen of What Cou	ntry?
be filed within 72 hours after death with the Marylar ital Hygiene. Id other than "naturel", or items 23a or 28a-f show event, the Madical Examinat must be notified at	by Fune	11. Marital Status 1 □ Never Married 2 □ Married 1 □ Never Married 2 □ Married 1 □ Yes, Give 1 □ Yes, Give 1 □ Yes, Give 1 □ Yes, Give 1 □ Yes, Give 1 □ Yes, Give 1 □ Yes, Give 1 □ Yes, Give 1 □ Yes, Give		Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 No Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ameri Black, White, Specify: B	
within 72 hou ene. than "nature he Medical E	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	(Give	dent's Usual Occupation kind of work done during most of work DO NOT use retired)	ing 16b	. Kind of Business/Ir	ndustry
d be filed wental Hygier to event, It.	Be	17. Father's Name (First, Middle, Last)	PACE	18. Mother's Nam	(First, Middle, Maid		I PALLETT C
and 2 should be saith and Mental n 27 is marked in traumatic even	T ₀	19a. Informant's Name/Relationship (Type, Print) CORA JUHNSON ~ MOTHE	19b. Mailir	ng Address (Street and Number or Run		U SON y or Town, State, Zij	0 Code)
permit. Pages 1 and 2 should Department of Health and Men Important: If Item 27 ie marke any Injury or other traumatic			Ob. Place of Dispo cemetery, crei	matory or other place)	Date 20c.	Location - City or T	own, State
Physician /Medical		23a. Part 1. Enter the disease, or samplication, that caused the shock, or heart vilure. List only one seed on each line. Immediate Cause (Fit I disease or condition resulting in death) Due to (or as a co	CARDIO	19 N 9 T, ter the mode of dying, such as cardiac	Pocomo de respiratory arrest,	KE, MO.	Approximate Interval Between Onset and Death
icate be executed physicien and she burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b.	F HEART insequence of):	FAILURE			G YRS.
் ≡ கை	Medicai	d. NIDOM					5 YRS
The law requires that the death certific te has been signed by the attending p	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	Fetal death 3	Ectopic pregnancy Other (specify)		23d. Date of delive Month	ery Day Year
w requires that the debeen signed by the should be detached	b	Part II. Other significant conditions contributing to death but no DYSLIFIDEMIA	it resulting in the u	ndertying cause given in Part I.		o use contribute to t	he cause of death?
	e Completed	25. Was case referred to medical			24a. Was an autopsy performed 1 Yes 2 2	prior to co death?	psy findings available impletion of cause of 2 No
ng Phy Iter this	To B	examiner?	2 ER/Outpatier 28b. Time of Injury	of 28c. Injury at Work?	me 5 Residence 28d. Describe how in		(y)
ital or Attendir us after death. rel Director: Al	Certification;	3 Suicide 6 Could not be determined 28e. Place of Injury - building, etc. (S	At home, farm, str pecify)	reet, factory, office	28f. Location (Street City or Town, St.	Ai/4	
To the Hosrital or within 24 hours after To the Funeral Dire completely filled in E	Medica	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my and manner stated.	/ knowledge, deatl mination and/or in	vestigation, in my opinion, death occurr	ed at the time, date a	and place, and due to	the cause(s)
vitl To con	5	29b. Signature and title of certifier Who Mb		29c. License number 050919	29d. (Date signed (Month,	Day, Year)
K) -	ah	30. Name and address of person who completed cause of death	5 OHS	ASM YEAR MANAGEMENT	y MO	2/309	
St Regist	ate rar	31. Date filed (Month, Day, Year) NOV 0 4 2004 Service 32. Registrar's :		all			

DHMH 17 Rev 1/2001

Registrar

			1 - For State Registrar	State of M	Maryland / Dep <i>Ce</i>	artment of H			iene .g. No 2004	36797
	Physici		1. Decedent's Name (First, Middle Frances C.	Jester				2. Date of Deat Month	Day Year 3, 2004	3. Time of Death 1:40 A. M
	/Medio Examir		4a. Facility Name (If not institution	, give street and number	or)	4b. City, Town, or	Location of D		4c. County of Deat	
	ZAGIIII	,	Northampton 1	Manor Healt	h Care	Freder			Frederi	
	Funeral Director		5. Social Security Number 424–14–1915		Age (In yrs. last birthday) 81 Yrs.	If Under 1 Year Months Days	If Under 24 Hours M	Hrs. 8. Date of Birth (Month, Day, Sept. 24	9. Bin (Co 4, 1923 Alal	hplace (State or Foreign untry)
	p ,		Usual Residence of Decedent		140.00.7					
	anyla shov	7	10a. State 10b. County		10c. City, Town or Lo					10d. Inside City Limits 1 X Yes 2 □ No
	Ne M	Director		erick	Walke	rsville				
	with a or		10e. Street and Number	D1		10f. Zîp Code	2	10	og. Citizen of What Co	•
	eath	erai	313Fa11sworth	12. Was Deceder	at Ever in II S 12	2179		1/Caratt. Van an Na	United St	
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If Item 27 is marked other then "naturel", or Items 23s or 28e-f show eny injury or other treumetic event, the Mcdical Examiner must be nutified at once.	by Funerai	1 Never Married 2 Marr 3 Widowed 4 Divorced	Armed Force:	s? X No	If Yes, specify Cuba 1 ☐ Yes 2 X No		(Specify Yes or No- uerto Rican, etc.)	14. Race - Ame Black, White Specify: Wh	e, etc.
5-0	72 ho	Completed	15. Deceden (Specify only highes		16a. Dece	dent's Usual Occupa	ation	working 1	6b. Kind of Business/	Industry
2	ithin ne. hen."	Jd I	Elementary/Secondary (0-12)	College (1-4o	r 5+)	DO NOT use retired)		-	
7	lled v tygie her ti		17 Enthada Nama (First Midella	(cost)	Supp	ly Manage				Communication
anc	ntal Hed ot	Be	17. Father's Name (First, Middle, William Caldwe					Name (First, Middle, M 1 de Hinden	faiden Sumame)	
Ž	should id Me mark metic	ဥ	19a. Informant's Name/Relations	A STATE OF THE STA	19h Maili	nn Address (Street a		Rural Route Number,	City or Town State 3	iin Code l
Maryland	nd 2 s lith ar 27 is r treu		Harriet Embrey					Walkersvi		
Baltimore,	Pages 1 and 2 nent of Health out: If item 27 ary or other tru		20a. Method of Disposition 1 Burial 2 remation 4 Donation 5 Other (S		θ	osition (Name of matory or other place k Cremato	' NT	F 200/	Oc. Location - City or	
<u>===</u>	mit. I partm sorter rinju		21. Signature of Funeral Service				- 1	tauffer Fu		
m	Deparenti Imporential		1 ountrus	Starlber				Pike, Fred		
	/Medical Examiner	Examiner	23a. Part1. Enter the disease, or shock, or heart failure. List immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	a. Chy Due to (or a	ed the death. Do not entitle. BY A consequence of): Is a consequence of):	er the mode of dying	g, such as card	fliac or respiratory arre	st.	Approximate Interval Between Onset and Death
x 68760,	sertificate be executed ding physician and se as the burial-transit	dicai	resulting in death) Last IF FEMALE:	d	as a consequence of):					
.O. Box	the death certific y the attending p iched for use as	by Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 ☐ Live birth	2 Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of deli Month	very Day Year
ري ص	n requires that the de been signed by the s should be detached to	d by Pl	Part II. Other significant condition Dialectes	ns contributing to death	but not resulting in the u	nderlying cause give	on in Part I.		acco use contribute to	,
Division of Vital Record	The lay	Completed						24a. Was an autopsy perform	prior to c	opsy findings available ompletion of cause of
Ziti	icien sertifi ector	Be	25. Was case referred to medical examiner?	Hospital:		0#	-	eath (Check only one		
o	Physicien: rthis certifica ral director, I	5	1 Yes 2 No	i 1 ∐inpa	tient 2 ER/Outpatier		4 🖭 NUISING	g Home 5 Residen		ify)
L	ting l	ion	27. Manner of Death 1 Natural 5 Pendin		jury 28b. Time of Injury	Work		28d. Describe hov	v injury occurred	
Divisio	To the Hospitel or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	Certification:	2 Accident investig 3 Suicide 6 Could r 4 Homicide determ	not be 28e. Place of Is	njury - At home, farm, str etc. (Specify)		/es 2□No	28f. Location (Stre City or Town,	eet and Number or Rui State)	al Route Number,
	To the Hospitel within 24 hours a To the Funerel Completely filled	edical C	29a. Certifier 1 Certifyin (Check only one) 2 Medical I	g Physician: To the bes Examiner: On the basis and manners	st of my knowledge, death of examination and/or in- stated.	n occurred at the time vestigation, in my op	e, date and pla inion, death oc	ice, and due to the cau courred at the time, dat	use(s) and manner as e and place, and due	stated. to the cause(s)
j	To the within To the comp	M	29b. Signature and title of certifier	laque MD) .	29c. License	number 5403	36	d. Date signed (Month)	Day, Year)
	j.D		30. Name and address of person	Hague	100 M	Print)	ire p	ive Fred	derick is	nd 21701
	Sta Registr		31. Date filed (Month, Day, Year)		trar's Signature	& Spar	K			

DHMH 17 Rev 1/200

			State of Maryland / Departs		
		•	1 - State Certif	ficate of Death	Reg. No 2004 36798
ı	Physici	an	1. Decedent's Name (First, Middle, Last)	Mo	
	/Medio Examin		Alverta O. Jones 4a. Facility Name (If not institution, give street and number) 4b.	b. City, Town, or Locetion of Death	rember 1 2004 5:15 a ^M 4c. County of Death
		ŭ.		Millersville	Anne Arundel
	Funeral Director		1 M 2 TVF	f Under 1 Year If Under 24 Hrs. 8. Date on this Days Hours Min. (Mo	te of Birth 9. Birthplace (State or Foreign Country) 2 15 1920 Maryland
	ס		Usual Residence of Decedent		
	show	o.	10a. State 10b. County 10c. City, Town or Locati		10d. Inside City Limits 1 ☐ ★es 2 ☐ No
	the N	Director	Maryland Anne Arundel Gambrills 10e. Street and Number	S 10f. Zip Code	10g. Citizen of What Country?
	th with	ai Di	2540 Brickhead Road	21054	USA
	tems	uner		s Decedent of Hispanic Origin? (Specify Yees, specify Cuban, Mexican, Puerto Rican, o	ss or No- etc.) 14. Race - American Indian, Black, White, etc.
36	irs afte	by Funerai	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No If Yes, Give 1 ☐ Year or Dates:	Yes 2 No Specify:	Specify: Black
21215-0036	within 72 hours after death with the Maryland ane. than "natural; or Items 23a or 28a-f show the Medical Exar, or Items Lectivitified at	Completed	(Specify only highest grade completed) (Give kind	t's Usual Occupation d of work done during most of working	16b. Kind of Business/Industry
121	within ane. than	mpi	Elementary/Secondary (0-12) College (1-4or 5+)	NOT use retired)	Knollwood Manor Nursing Home
d 2	Hygie other ent, I	Be Co	7th 0 Last	aundry 18. Mother's Name (First,	Middle, Maiden Surname)
/lan	Mental Mental Mrked	To B	Thomas T. Ridgley	Mary F.	Queen
Maryland	2 sho and I is mu			Address (Street and Number or Rural Route	
	Health Health tem 27		20h. Mathed of Disposition 20h. Place of Disposition	on (Name of Date	Gambrills, Md. 21054 20c. Location - City or Town, State
ē	Pages ient of nt: If ii ry or o		1X Burial 2 □ Cremation 3 □ Removal from State Mt. Tabor '4 □ Donation 5 □ Other (Specify) Church Cen	c UM netery 11/6/04	Chesterfield, Md.
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Exart and interactive rightled at once.		21. Signature of Funeral Service Licensee 22. No	ame and Address of Facility	
	205 29		Lavry M. Reese Moo 183 82;	Reese & Sons MC West St. Annaps	olis, Md. 21101 Approximate
4	Dhuaisian		shock, or heart failure. List only one cause on each line. Immediate Cause (Final	to mode of dying, oder as sarates of respir	Interval Between Onset and Death
4	Physician /Medical		resulting in death) a. Due to (or as a consequence of):		4640
	Examiner		Sequentially list conditions, b. Due to (or as a consequence of):		
	rted	Examiner	cause. Enter Underlying. Cause (Disease or injury		
o,	execu an and rial-tra		that initiated events c. resulting in death) Last Due to (or as a consequence of):		
8760,	death certificate be executed e attending physician and of for use as the burial-transit	dical	d		
89 x	certific Iding p	Physician/Medi	IFFEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant		23d. Date of delivery
. Box	death e atter ed for L	iciar	in the past 12 months?	topic pregnancy ther (specify)	Month Day Year
P.O.	nat the d by th etache	Phys	9 Unknown Part II. Other significant conditions contributing to death but not resulting in the under	shing course given in Part I	Be. Did tobacco use contribute to the cause of death?
	w requires that the deben signed by the should be detached	þ	Part II. Other significant conditions contributing to death out not resulting in the under	Trying cause given in ratti.	1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💋 Inknown
cor	law requas been 2 shoul	Completed		24	a. Was an 24b. Were autopsy findings available
Re	o ~ o	mo		10	autopsy prior to completion of cause of death? ☐ Yes 2 No 1 ☐ Yes 2 ☐ No
/ita	Physician: Th rthis certificate ral director, pag	Be	25. Was case referred to medical examiner?	26. Place of Death (Chec	
of	Physic rthis ral dir	5	27. Manner of Death 28a. Date of Injury 28b. Time of	28c. Injury at 28d. De	Residence 6 Other (Specify)
ion	ath. r: Afte	atlor	2 Accident investigation	Work? M 1 ☐ Yes 2 ☐ No	
Division of Vital Records,	or Atter fler de lirecto n by th	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, building, etc. (Specify)		cation (Street and Number or Rural Route Number, y or Town, State)
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death or	courred at the time, date and place, and due	e to the cause(s) and manner as stated.
	n 24 h n 24 h he Fur pletely	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigated and manner stated.	tigation, in my opinion, death occurred at th	ne time, date and place, and due to the cause(s)
	withi To t	Σ	29b. Signature and Jittle of certifier	29c. License number	29d. Date signed (Month, Day, Year)
			20 Name of disease of passes who completed cause of death (from 23a) Type Bris	1)3/136	NOVEMBER 3, 2004
			30. Name an ddress of person who completed cause of death (Item 23a) (Type, Pringle 1) and the completed cause of death (Item 23a) (Type, Pringle 2) and the completed cause of death (Item 23a) (Type, Pringle 3). Date filed (Month, Day, Year) and the completed cause of death (Item 23a) (Type, Pringle 3). Date filed (Month, Day, Year) and the completed cause of death (Item 23a) (Type, Pringle 3). Date filed (Month, Day, Year) and the completed cause of death (Item 23a) (Type, Pringle 3). Date filed (Month, Day, Year) and the completed cause of death (Item 23a) (Type, Pringle 3). Date filed (Month, Day, Year) and the completed cause of death (Item 23a) (Type, Pringle 3). Date filed (Month, Day, Year) are completed cause of death (Item 23a) (Type, Pringle 3). Date filed (Month, Day, Year) are completed cause of death (Item 23a).	KILBKIDE RO	AD BATHLE MOZIES
		ate	31. Date filed (Month, Day, Year) 32. Fingistrar's Signature	add a	
	Regist	rar	NOV - 3 ZUU4		

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 1- State Registrar AMEND#29cperMD11/4/04,BMW,McCo Certificate of Death Reg. No 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** October 25, 2004 5:35 P Gerald Leonard KITAY /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Washington Adventist Hospital Takoma Park tt Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Months Days Hours Min. (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1√2 M 2□ F Yrs. 075-32-4393 Director 65 Sept. 21, 1939 New York Usual Residence of Decedent the Maryland 10c. City, Town or Location 1∩a State 10h County 10d. tnside City Limits 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Director Maryland Montgomery Gaithersburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or items 23a or 20877 United States 3 Sanders Court Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give △ Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If itam 27 is marked othar than "natural", or iten any injuryer othar traumatic event, the Madical Exp. unranonce. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√☐ No Specify Specify: white 3 ☐ Widowed 4 ☐ Divorced 15 Decedent's Education 16a. Decedent's Usual Occupation 16h Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Psychologist Psychology 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Gertrude Kotin Murray Kitay ဂ္ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gloria Kitay, Wife 3 Sanders Court, Gaithersburg, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 →Burial 2 Cremation 3 Removal from State Mt. Lebanon Cemetery 10/28/04 Adelphi, MD • 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service/License6 22. Name and Address of Facility Torchinsky Hebrew Funeral Home 254 Carroll St. NW. Washington, DC shock, or heart ailure. List only one cause on each line. 20012 Approximate Interval Between Onset and Death Immediate Cause (Final SEPSIS **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Rausa Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury ARMONYOPATHY - ISCHEMIC as the burial-transit that initiated events resulting in death) Last The law requires that the death certificate be execu Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician Physician/Medicai IF FEMALE use 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? detached for 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No the 9□ Unknown 9 Unknown ģ signed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by GONADISM 1 ☐ Yes 2 ☐ TO 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 1 Yes 2 No 은 Impatient 2 ER/Outpatient 3 DOA 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: After 5 Pending investigation 1XNatural after death. 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 6 ☐ Could not be 28e. Place of tnjury - At home, tarm, street, factory, office building, etc. (Specify) determined 4 Homicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai 29c. License number D44957 29b. Signature and title of certifier 29d. Date signed (Month. Day. Year) Name and address of person cause of death (Item 23a) (Type, Print) 7600 31. Date tiled (Month, Day, Year) State NOV 04 2004 Registrar

State of Maryland / Department of Health and Mental Hygiene 1- State Racistrar AMEND #26 PER PHYS 11/5/04 CCHD DB Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death October 30,2004 **Physician** 3:20a Patricia Ann Kemp /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 2211 Garden Lane Bryans Road Charles If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day Year) May 24, 1945 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 ☐ M 2 1 F Months Days Min Hours Washington D.C. 577-64-1533 59 Yrs **Director** Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ir than "natural", or Itams 23s or 28s-f show The Medical Examilier of the notified at 1 Yes 2 No Director Washington D.C. D.C. None 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number death with 20020 U.S.A. 2471 Alabama Ave., S.E. Funeral Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. s filed within 72 hours after de l Hygiene. othar than "natural", or Itam 1 Yes 2 No
If Yes, Give
Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🖁 No Baltimore, Maryland 21215-0036 Specify Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Smithsonian U.S. Government othart permil. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked othu any injury or other traumatic avent. QRR8. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Robert G. Kemp, Sr. Mary Helen Newman ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2211 Garden Lane, Bryans Road, Md. 20616 Georgette Brown sister 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) November 2, 20a. Method of Disposition 1 ☐ Burial X☐ Cremation 3 ☐ Removal from State Metropolitan Funeral Service Alexandria, Virginia 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licenses ^{22. Name and Address of Facility} Williams Funeral Home, P.A. 4270 Hawthorne Rd., Indian Head, Md. 20640 M00668 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or head failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician HNCREA /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner burial-transit certificate be executed Due to (or as a consequence of): attending physician Box 68760 ician/Medical as the l IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ō in the past 12 months? Month Year Day 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 ☐ Unknown Division of Vital Records, P.O. the detached Physi 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by The law requires þв 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an has autopsy performed? certificate 1 ☐ Yes 2QND To the Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) SISTER'S Other: 4 Nursing Home dence 6 MOther (Specify) HOUSE Hospital: 1 ☐ Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA 20 No 2 1 🗌 Yes this in by the funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred After Certification: 1 Matural
2 Accident 5 Pendina 2 □ No death. investigation 1 Tes after death 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Madical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical 29d. Date signed (Month. Day. Year. 29b. Signature and title of certifier 29c. License number Horse 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 0 0 911 31. Date filed (Month, Day, Year) oistrar's Signature State NOV 05 2004 Registrar

			For State	State of Ma	aryland /	•			Mental Hygi	ene	
			* Registrar			Certifica	ate of D	eath		9. NO 0 14	36801
ı	Physici	an	Decedent's Name (First, Middle, L.	ast)					2. Date of Death Month	Day Year	3. Time of Death
	/Medic		Bertha Gomb						October		12:01 P M
	Examin	er	4a. Facility Name (If not institution, gr	ve street and number)				ocation of Death	1	4c. County of Dea	ith
			Carriage Hill 5. Social Security Number 6.	Sex 7. Ag	e (In yrs. last b		ethesd	a If Under 24 Hrs.	8. Date of Birth	Montgome	
Н	Funeral Director			1□ M 2\\ F	88	Yrs. Month		Hours Min.	(Month, Day,)	1,1915 Ne	thplace (State or Foreign ountry)
	D		Usual Residence of Decedent						Decomber	1,1715 11	
	unylam show		10a. State 10b. County		10c. City, Tov	wn or Location					10d. Inside City Limits 1 □ Yes 2 X No
	8a-1	octo	Maryland Montgom	ery	Bethe						
	with ti	Funeral Director	10e. Street and Number			10t.	Zip Code	017	10	g. Citizen of What C	ountry?
	eath	erai	6120 Durbin Rd.	12. Was Decedent	Ever in U.S.	13. Was De		817	pecify Yes or No-	U.S.A.	erican Indian
"	riter d	표	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 🕅					pecify Yes or No- p Rican, etc.)	Black, Whi	te, etc.
93	ours a	by	3 Widowed 4 □ Divorced	If Yes, Give Year or Dates:		1 L Yes	2 X No	Specify:		Specify: Wh:	ite
5-0	within 72 hours atter death with the Maryland ene. than "natural", or items 23e or 28e-1 show ta Mailcal Exercition cust be civilified at	Completed by	15. Decedent's l (Specify only highest g	Education rade completed)	168	a. Decedent's U (Give kind of	sual Occupat work done du	ion iring most of wor	king 10	6b. Kind of Business	
121	within ne.	mpi	Elementary/Secondary (0-12)	College (1-4or 5	i+)					D .	
2	illed v Hygie ther t		17. Father's Name (First, Middle, Las	4		Interi			ne (First, Middle, Ma	Business	3
and	d be anntal	To Be	William Gomberg	,				Lizza (,	
Maryland 21215-0036	shoul nd Me mari	-	19a. Informant's Name/Relationship	(Type, Print)	19	b. Mailing Addr	ess (Street ar	nd Number or Ru	ral Route Number,	City or Town, State, .	Zip Code)
	alth a alth a 27 is		Laurence S. Kirs	ch-Son	72	212 Lon	gwood :	Dr. Beth	esda, MD	20817	
ore	of He		20a. Method of Disposition 1X Burial 2 Cremation 3	Demoval from State	20b. Place o	of Disposition (I	Name of or other place,)	Date 20	Oc. Location - City or	Town, State
Ĕ	Pag ment ant: t		`4 □Donation 5 □ Other (Spec	ify)	King I	David C		y 10/2	29/2004 Fa	alls Churc	ch, VA
Baltimore,	perrili. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show among injury or other traumetic event, if a Marical Extending Control of the notified at once.		21. Signature of Funeral Service Lic	nsee		22. Name	and Address	of Facility Hir	nes-Rinalo	di F.H.	1/
	40 2 8 Q		200 Part Enter the disease Street	meliantians that assumed	the death. De	1180	0_New_	Hampshir	e Ave. Si	ilver Spri	no MD 20904 Approximate
			23a. Part. Enter the disease, or conshock, or heart failure. List onl	y one cause on each lin	10.	THOU SHIEL WIS II	lode or dying,	Sucri as cardiac	or respiratory arres	ot,	Interval Between Onset and Death
	Prysician / /Medical		disease or condition resulting in death)	a. Metastat	ic Lung	Disea	se, un	known et	iclogy		less 6 month
	Examiner						scular	Disease			Years
	D =	ner	Sequentially list conditions, any, leading to immodiate cause. Enter Underlying Cause (Disease or injury that initiated events	b. Hyperter	a consequence	of):	SCULCIL	1/130/180			Itara
	acute ind trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Coronary	Artery	Disea	86				Years
760,	ate be executed sysician and he burial-transit	cai E		Due to (or as	a consequence	9 (1):					
687	physicate sthe			d.							
Box (that the death certitical ed by the attending phy detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome						23d. Date of de	livery
	death e atte	Icial	in the past 12 months? 1 ☐ Yes 2 ☑ No	1□Live birth 4□Pregnant at		h 3 ∐Ectopio 5 ☐ Other	pregnancy (specify)			Month	Day Year
0.	of the	hys	9 ☐ Unknown 1	9□ Unknown							
s, P	es tha gned be de	by F	Part II. Other significant conditions				-				the cause of death?
ord	w requires to been signer should be	ted	Dementia, Hydron			Lumor	presum		1 L Yes	2 L ∆ LNo 3 □ Pr	robably 4 Unknown
ec	G 85 C1	Completed	metastatic, Bla	dder Cancer	<u> </u>				24a. Was an autopsy	prior to	utopsy findings available completion of cause of
al Fi									performe		2 💢 No
Vital Records,	iding Physician: th. After this certifical funeral director,	Be c	25. Was case referred to medical examiner?	Hospital:	· • • • • • • • • • • • • • • • • • • •				th (Check only one)		
of	Phys or this oral di	. To	1 ☐ Yes 2X No 27. Manner of Death	28a. Date of Inju	ry 28b.	Time of	28c. Injury a	at	28d. Describe how	ce 6 Other (Spe	cify)
ion	Attending r death. ector: After	ation	1 X Natural 5 ☐ Pending 2 ☐ Accident investigati	(Month, Daj	y Year)	Injury M	Work?	s 2 No			
Division	of or Attendinated of the strength. Director: Af din by the further of the furth	Certification:	3 ☐ Suicide 6 ☐ Could not determine		ury - At home, f	arm, street, fac	tory, office		28f. Location (Stre City or Town,	et and Number or Ru State)	ural Route Number,
$\overline{\Box}$		40									
	ital o				of my knowlada				and due to the cau	se(s) and manner as	
	Hospital or the hours aft Funeral Distribution in the telegraph in the tel		(Check only 2 Medical Ext	Physician: To the best aminer: On the basis of	examination a	ge, death occurr nd/or investigat	ed at the time ion, in my opir	, date and place, nion, death occur	red at the time, date	e and place, and due	stated. to the cause(s)
	o the Hospital or ithin 24 hours aft of the Funeral Di impletely tilled in	Medical Ce	29a. Certifier (Check only one) 1 Certifying F 2 Medical Ext	Physician: To the best aminer: On the basis of and manner sta	examination a	nd/or investigat	ed at the time ion, in my opii	nion, death occui	rred at the time, date	e and place, and due d. Date signed (Mont.	to the cause(s)
	To the Hospital or Atter within 24 hours after de To the Funeral Directo completely lilled in by the	edicai	one)	iminer: On the basis of	examination a	nd/or investigat	ion, in my opii 29c. License i	nion, death occui number	rred at the time, date	e and place, and due	h, Day, Year)
)	To the Hospital or within 24 hours aft To the Funeral Di completely tilled in	edicai	one)	aminer: On the basis of and manner sta	examination al	nd/or investigat	ion, in my opir	nion, death occui number	rred at the time, date	e and place, and due	h, Day, Year)
•	To the Hospite within 24 hours To the Funeral completely tille	edicai	29b. Signature and title of certifier	aminer: On the basis of and manner sta	eath (Item 23a)	nd/or investigat	29c. License i	nion, death occur number 79	29c	e and place, and due	h, Day, Year)
	To the Hospite within 24 hours To the Funeral completely tille	Medical	29b. Signature and title of certifier 30. Name and address of person who	o completed cause of d	eath (Item 23a)	(Type, Print)	29c. License i	number 79 a, MD 20	29c	e and place, and due	h, Day, Year)

DHMH 17 Rev 1/2001

11.0	ii Kaetz		For State Registrar	State of Ma	aryland / Dep <i>Ce</i>	artment of I			giene) l 36802
	Physici		1. Decedent's Name (First, Middle, Last)	William	Daniel	Kaetzel	-	2. Date of Dea Month Novembe	Day	3. Time of Death 904 13:58 M
7	/Medic Examin		4a. Facility Name (If not institution, give st Washington County			1	or Location of Dea		4c. County o Washin	of Death
	Funeral Director		5. Social Security Number 216-90-3903 6. Sex 100 Usuel Residence of Decedent	7. Age M 2□F	41 Yrs. last birthday,	If Under 1 Year Months Days			^h 7, Year) 22 1963	9. Birthplace (State or Foreign Country) Maryland
	death with the Maryland ms 23a or 28a-f ahow rmust be notified at	_	10a. State 10b. County		10c. City, Town or L					10d. Inside City Limits 1 ¥Yes 2 □ No
	r 28a-1 ahow	Director	Penna. Franklin 10e. Street and Number		Greenc	astle 10f. Zip Code			10g. Citizen of Wi	
	23a or		305 S. Washington	St.		1722	5		U.S.A.	,.
980	or ite	by Funeral	11. Marital Status 1 1 Never Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent E Armed Forces? 1 XYes 2 N If Yes, Give Year or Dates: 1	lo	Was Decedent of I If Yes, specify Cub 1 ☐ Yes 2 No	an, Mexican, Pue	Specify Yes or No- rto Rican, etc.)		- American Indian, K, White, etc. White
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours InDepartment of Health and Mental Hygiene. Inportant: If item 27 is marked other than "natural! any injury or other traumatic event, the Medical Exonce.	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0·12)	ation completed) College (1-4or 5	+) (Give	dent's Usual Occup kind of work done DO NOT use retire	during most of we	orking	16b. Kind of Bus	
d 2	illed in Hygie other fent, It	Be Co	17. Father's Name (First, Middle, Last)		II	ason	18. Mother's Na	ıme (First, Middle,		·
ylar	ould be Menta arked atic ev	To B	David M.					nie L. Mi		
Mar	d 2 sho th and th is m traum		19a. Informant's Name/Relationship (Type Beth A. Kaetzel/W	•				iumi Route Numbe Greenca		
Baltimore,	Pages 1 an lent of Heal nt: If item 2 ry or other		20a. Method of Disposition 1		20b. Place of Disported St. Mark Church C	osition (Name of	1	Date /15/04	20c. Location - C	City or Town, State
Balti	permit. Departm Importa any inju		21. Signature of Funeral Service Licenses	meire	Z Z	2. Name and Addre immerman	And Son	Funeral Greenca	Home Inc	2. 1. 17225
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8760,	rate be executed shysician and the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter ungertying Cause (Disease or injury that initiated events resulting in death) Last		a consequence of):	200.00				
.O. Box 687	ne death certific the attending p thed for use as	Physician/Medlo	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal death 3	⊒Ectopic pregnanc ⊒ Other (specify) _	у		23d. Date Monti	of delivery th Day Year
<u>α</u>	v requires that the bear signed by should be detact	by	Part II. Other significant conditions cont	ributing to death bu	at not resulting in the u	inderlying cause gr	ven in Part I.			bute to the cause of death? B Probably 4 Unknown
Vital Records,	(0 77	Completed					***	24a. Was a autops perfor	sy pri med? de	ere autopsy findings available ior to completion of cause of sath?
Vita	Physician: Th rthis certificate ral director, paç	Be	25. Was case referred to medical examiner?	spital:	1#V	- Ott	200	ath (Check only or		
of	Attending Phys ir death. ector: Atter this oby the funeral dir	atlon; To	1X Yes 2 □ No □ □ No 27. Manner of Death 1 □ Natural 5 □ Pending	1 ☐ Inpatiel 28a. Date of Injur (Month, Day		t 28c. Inju	ry at	Home 5 □ Residence 128d. Describe hasket c) €	ow injury occurred	d Decocued in
Division	i Pite	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Inju- building, etc	iry - At home, farm, st : (Specify)	reet, factory, office	e	28f. Location (S City or Town	treet and Number n, State) 980 SHTON	r or Rural Route Number, 2 Permorcoke Pr. Co. MD
	Hospital 24 hours a Funeral etely filled	ledical	29a. Certifier (Check only one) 1 Certifying Physic 2 Medical Examination	cian: To the best of er: On the basis of and manner sta	of my knowledge, deat examination and/or in ted.	h occurred at the til vestigation, in my o	me, date and plac opinion, death occ	e, and due to the c urred at the time, d	ause(s) and manr late and place, an	ner as stated. nd due to the cause(s)
	To the within 2 To the comple	Me	29b. Signature and little of certifier	$\chi \mathcal{M}$	1	29c. Licens	o.C.M.			(Month, Day, Year)
	13)	30. Name and address of person who con	npleted cause of de			eet, Bal	timore, N		-
	Sta Registi	-	31. Date filed (Month, Day, Year) NOV 1 9 2004	32. Registra	r's Signature	park				

			For State Registrar	State of Ma	aryland /		artment of H		nd Men		000	4	36803
	Physici	an	1. Decedent's Name (First, Middle, La	st)						Date of Deat Month		Year	3. Time of Death
	/Medic	al	Albert Loc 4a. Facility Name (If not institution, give				4b. City, Town, or	l coation of		ovembe	er 1 20	004	06:50 A M
	Examin	er .	6001 Muncaster M		sev Ho	use	Rockvi		греап			tgom	erv
	Funeral		5. Social Security Number 6. S	Sex 7. Ag	e (In yrs. last i	birthday)	If Under 1 Year Months Days	If Under 2	24 Hrs. 8. [Min.	Date of Birth Month, Day,			lace (State or Foreign
	Director		571 54 3628 Usual Residence of Decedent	1 ⊠ M 2□F	67	Yrs.			A	ug. 14	1937		ifornia
	land ow		10a. State 10b. County		10c. City, To	wn or Lo	cation					1	Od. Inside City Limits
	• Many	ctor	Md. Monto	gomery	Po	toma	С						1 ☐ Yes 2 StNo
	or 28	Funeral Director	10e. Street and Number 8904 Barrowgate	Court			10f. Zip Code	20854	1	1	0g. Citizen of W		
	eath v	eral	11, Marital Status	12. Was Decedent	Ever in U.S.	13 \	Vas Decedent of His			Yes or No-	United		tes an Indian,
9	or Item	Fun	1 ☑ Never Married 2 ☐ Married	Armed Forces?			Vas Decedent of His f Yes, specify Cubar I □ Yes 2₩ No		Puerto Rica	in, etc.)	Black	, White,	etc.
003	urel', c	d by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:				Specify:			Specify:		ian ——————
21215-0036	within 72 hours after death with the Maryland ene. than "neturel", or Iteme 23e or 28e-f show the Malcal Everill at neat be notified at	Completed	15. Decedent's E (Specify only highest gr	ade completed)		Sa. Deced (Give life. l	lent's Usual Occupa kind of work done d DO NOT use retired,	ition <i>luring m</i> ost)	of working		16b. Kind of Bu	siness/Ind	dustry
212	d with giene.	mo	Elementary/Secondary (0-12)	College (1-4or 5 13)+)		cologist				U.S.	Gove	rnment
pu	s 1 and 2 should be filed within 72 hours after death with the Marylan I Health and Mental Hyglene. Item 27 is marked other than "neturel", or Iteme 23e or 28e-f show then treumatic event, the Modes Exertil or installe retitions.	Be	17. Father's Name (First, Middle, Last	")			4	18. Mother			Maiden Surname	e)	
Maryland	houtd d Men narke natic	ဥ	Fred Lock 19a. Informant's Name/Relationship	(Type Print)	1	9h Mailir	g Address (Street a				City of Town	State Zin	Codel
Ma	ulth an 27 ie r r treur			rother			Rising R						0817
Je,	ss 1 ar		20a. Method of Disposition		20b. Place ceme		sition (Name of natory or other place		Date		20c. Location -		wn, State
Ë	Page ment of our mont		1 ☐ Burial 2 ☑ Cremation 3 ☐ `4 ☐ Donation 5 ☐ Other (Speci		1	opol	itan Crem	۱.	11/2/		Alexand	ria,	Va.
Baltimore,	permit. Pages 1 and 2 Department of Health s Importent: If Item 27 is any injury or other tre		21. Signature of Funeral Service Lice Murcel	Ball	lur	22	Name and Addres Muriel H P. O. E	s of Facility L. Bar Box 50	ber F	uneral aytons	Home ville,	Md.	20882
			23a. Part1. Enter the disease, or con shock, or heart failure. List only	one cause on each ti	ne.		er the mode of dying	g, such as o	cardiac or res	spiratory arre	est,		Approximate Interval Between Onset and Death
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	ש אַ	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Discass or Hijury that initiated events		a consequenc	e of):							
_	kecute and I-trans	Examiner	that initiated events resulting in death) Last	cDue to (or as	a consequenc	e of):							
8760,	icate be executed physician and s the burial-transit	icalE		d	•								
9	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	ed	IF CTUAL F.										-2-11
Вох	leath certifica attending phi i for use as th	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome	2 Fetal dea		Ectopic pregnancy				23d. Date Mon		ny Day Year
P.O. I	the dea	yslc	1 □ Yes 2 □ No 9 □ Unknown	4□Pregnant at 9□Unknown	time of death	5 L	Other (specify)						
	res that the de signed by the a be detached f	by Ph	Part II. Other significant conditions	contributing to death b	ut not resultin	g in the u	nderlying cause give	n in Part I.		23e. Did tob	pacco use contri	bute to th	ne cause of death?
ords	w require been sig should b	led t								1 □ Ye	es 2⊠No	3 🗌 Prob	ably 4 Unknown
Records,	tawr nas be	Completed								24a. Was a autops perform	y p	ere auto rior to cor eath?	psy findings available npletion of cause of
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Vital	Physicien: r this certific ral director,	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:	ent 2 🗆 ERV	Outpatier	t 3 DOA Othe			heck only on 5 □ Reside	e) ence 6 ⊠fothe	r (Specifi	Hospice
n of	ding Physicien: The h. After this certificate hi funeral director, page	T :uc	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Inju (Month, Da		o. Time of			-		ow injury occurre		
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Division	after of Direction by	Certification;	4 Homicide determined	1 28e. Place of Inj	ury - At nome, c <i>. (Specify)</i>	, rarm, str	eet, factory, office		201.	City or Town	reet and Numbe n, State)	er or Hura	l Route Number,
	To the Hospitel or Attent within 24 hours after death To the Funerel Director; completely filled in by the	Medical C		hysician: To the best miner: On the basis o and manner st	f examination								
	To the within 2 To the complet	Me	29b. Signature and title of certifier				29c. License	number		2:	9d. Date signed	(Month,	Day, Year)
	15,	-	I Chihi ye	poul			D4	2452			Noveml	per 1	, 2004
	N		30. Name and address of person with Chitra Rajagop	al, M.D.	18111	Prin	Print) nce Phili	p Driv	ve, 01	ney, M	Md. 20	0832	
	Sta Regist		31. Date filed (Month, Day, Year) NOV 0 4 2		ar's Signature	5	Sparks						

			For State Registrar		arytand		rtificat			and ivi	ental Hyg	giene Reg. Me.	001	368	04
	Physicia		Decedent's Name (First, Middle, I								2. Date of Dea Month	ath Day	/ Yea	3. Time of	Death
	/Medic		Evelyn Latha						7 711-5		11	01	2004	8:39	am [™]
	Examin	er	4a. Facility Name (If not institution, g	give street and number)					Location of				County of De		
	Comment.		Holy Cross 5. Social Security Number 6	. Sex 7. Ag	e (In yrs. las	st birthdav)		1 Year	r Sp	24 Hrs.	8. Date of Birtl	M	ontgo		r Foreign
	Funeral Director	1	115 24 5138	1 □ M 2 🖾 F	74	Yrs.	Months	Days	Hours	Min.	8. Date of Birt (Month, Day 06/08	/, Year) /30	На	Birthplace (State of Country) rtfield	i.KY
P	>		Usual Residence of Decedent 10a. State 10b. County		10- City	Town or Lo									
fanyla	shov ed at	ō	Md Montg	omerv			Spri	ng						10d. Inside Ci	
the A	28a-	rect	10e. Street and Number				10f. Zip					10a. Citi	zen of What	Country?	
h with	3a or	by Funeral Director	2114 Randolp	h Road				090	2				SA	•	
deat	ems 2	ner	11. Marital Status	12. Was Decedent Armed Forces?		13.	Was Deced	dent of Hi	ispanic Orig	gin? (Spe	cify Yes or No- Rican, etc.)		14. Race - Ar Black, W	merican Indian,	
36 s after	or It	y Fu	1 Never Married 2 Married	1 ∏Yes 2∛⊡X If Yes, Give		1	1 ☐ Yes		Specify:	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,				Black	
21215-0036 od within 72 hours aff	Hygiene. vther than "natural", or tlems 23a or 28a-1 show ont. Itte Medical Examinat noust be notified at	ed b	3 ☐ Widowed 4 ☐ Divorced 15. Decedent's	Year or Dates:		16a Dece	dent's Usua	al Occupa	ation			16h Ki	nd of Busine		
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213 W Mitt	giene er tha	Completed	Elementary/Secondary (0-12)	2yrs	, ,	M	usic	ian					Priva	ite	
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Z la	and Mental I s marked of umatic eve	2	Jarvis Mosle	-		10h Maili	- Address	/C11			la McF Route Numbe			7:- 0- 1-1	
CV	th and 17 is mu traum		Robert Lee I				-							Spring,	. Md
L-	f Health tem 27 other tr		20a. Method of Disposition				osition (Nan		-		ate			or Town, State	-
MOF	o History		*☐ Burial 2 ☐ Cremation 3 `4 ☐ Donation 5 ☐ Other (Spe		ì		Hear		9)	11/1	0/04	Sil	ver S	Spring,	4d
Baltimore,			21. Signature of Funeral Service Lie	censee S					nera rgia	ł Ho Ave	me _{&} Ci			Servic n,DC 20	
			23a. Part1. Enter the disease, or co shock, or heart failure. List or	omplications that caused by one cause on each li	the death. ne.	Do not ent	er the mod	e of dying	g, such as	cardiac o	r respiratory ar	rest,		Approximate Interval Bety	veen
	nysician	0 1	Immediate Cause (Final disease or condition	_ Sepsi	s									Onset and D	
	Medical xaminer		resulting in death)	Due to (or as			m							F 20	
		e.	Sequentially list conditions, if any, leading to immediate cause. Enter Uncertainty	b. Aspir			eumor	ша						5days	<u> </u>
pejn	d ansit	Examiner	Cause (Disease or injury that initiated events	Strok	.e									6weel	ζS
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68760, ificate be ex	physician and s the burial-transit	dical		d		-									
X 6	attending p	/Med	IF FEMALE:	23c. If yes, outcome	of pregnance	ev.			***			Π,	23d. Date of c	dolivany	
Box leath cert	atten I for u	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐Live birth 4 ☐ Pregnant at	2 Fetal d	eath 3	Ectopic pr Other (sp					1	Month Month		еаг
P.O.	ned by the a detached t	hysl	9 Unknown	9□ Unknown							-				
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eco law re	has been ge 2 should	Completed	Diabetes								24a. Was a			autopsy findings a o completion of ca	
	ate ha	Com									perfor	med?	death 1 ☐ Y	?	
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of Vita Physician:	this aldin	To.	1 ☐ Yes 2 ☐No 27. Manner of Death	Hospital:		R/Outpatier 8b. Time o			4 111		ne 5 🗌 Resid			pecify)	
	h. After funera	tlon	14 Natural 5 ☐ Pending 2 ☐ Accident investiga	28a. Date of Inju (Month, Da	y Year)	Injury	M	8c. Injury Work 1 □ 1	ດີ Yes 2 ∐ I		od. Describe II	OW IIIJUI	y occurred		
Division I or Attending	r death.	Certification:	3 Suicide 6 Could no	t be 28e. Place of Inj	ury · At hom	e, farm, str	eet, factory				8f. Location (S	treet an	d Number or	Rural Route Numb	oer,
Di	s afte	Cert	4 [] Homicide	building, et	c. (Specify)						City or Tow	n, State,	,		
lospi	within 24 hours after deatl To the Funeral Director: completely filled in by the	Medical	29a. Certifier 1. Certifying (Check only 2 Medical Ex	Physician: To the best taminer: On the basis o and manner st	f examinatio	edge, deat n and/or in	h occurred vestigation	at the tim , in my op	ie, date and pinion, deat	d place, a th occurre	and due to the ded at the time, o	ause(s) date and	and manner place, and d	as stated. ue to the cause(s)	
2	C 4 9	a)													
To the Hospital	within To the comple	Me	29b. Signature and title of certifier		/		290	. License	number					nth, Day, Year)	
To the h		Me	1 Anner	idlo A	Quen	. M-i			7630)			e signed <i>(Mo</i>		
To the t	within To the comple	Me	29b. Signature and title of certifier Multiple Signature and address of person with Anuradha Aru				Print)	0005	7630	-		11/	01/04		2

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. U () 4 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 11:09AM CATHERINE OWE 2004 AMME / 1 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner OT CATHERINE NSG SBURG FREDERICK CENTER EMMIT 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Apr. 14, 5. Social Security Number Birthplace (State or Foreign Country) Funeral 1 □ M 2 1 F 215-20-8277 Director Maryland Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a State 10h County 10d. Inside City Limits 28a-f show Examiner must be notified at Maryland Frederick County Emmitsburg 1 Yes 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with ò 285 De Paul Street 21727 Itams 23a United States death v Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No 14. Race - American Indian, Black, White, etc. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 2 should be filed within 72 hours after on and Mental Hygiene. Is markad othar than "natural", or Itar 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 No Specify If Yes, Give Year or Dates: þ 3 X Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) traumatic evant, I'm Madical 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) homemaker own home 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be John Linga Jane Baker ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a, Important: If itam 27 Is any injury or othar trau <u>once.</u> Jill Hooper / daughter 10 Weil Drive Thurmont, Maryland 21788 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Nov. 15 20c. Location - City or Town, State 1 ☐ Burial 2 💆 Cremation 3 ☐ Removal from State Smithsburg Crematorium Smithsburg, Maryland 2004 ' 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Skiles Funeral Home 21. Signature of Funeral Service Licens 210 West Main Street Emmitsburg, MD 21727 Han Turn 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician 5Ta92 disease or condition resulting in death) /Medical Due to (or as a consequency of): Examiner ZHEIME Sequentially first conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner burial-transit Due to (or as a consequence of): Box 68760, attending physician Physician/Medical the as IF FEMALE: nse s 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? for Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.0 the 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Wasan autopsy performed? 1 ☐ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After Certification: To the Hospital or Attanding Natural 2 Accident 5 Pending investigation 1 🗌 Yes death. 2 No after death 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 \ Homicide within 24 hours a To the Funeral D 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month. Dav. Year) 29b. Signature and title of certifier 29c. License number 30 Name and address of person who completed cause of death (Item 23a) (Type, Print) 5-2 THURMON

State Registrar 31. Date filed (Month, Day, Year)

NOV 1 9 2004

32. Registrar's Signatur

Please Type or Print in Black Indelible Ink.	Ensure All Copies Are Legible
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			State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. N2 0 (04 36806
	Discolation in the		Decedent's Name (First, Middle, Last) 2. Date of Death Month Day	3. Time of Death
100	Physicia /Medic	al	JENNY JANETTE PALMER LOWE November 7 20	004 10:05A ^M
8	Examin	ier		cester
	. Funeral Director		5. Social Security Number 6. Sex 1 M 2 F 86 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min. Sylvar) 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min. Sylvar) 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min. Sylvar) 8. Date of Birth (Month, Day, Year) 5/16/1918	9. Birthplace (State or Foreign Country) SC
	yland how		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location	10d. Inside City Limits
	Ba-1 sl	ector	MD Wicomico Salisbury	1 X Yes 2 □ No
	Se or 2	IDIr	10e. Street and Number 4859 Meadowlark Dr. 10f. Zip Code 21804 USA	/hat Country?
980	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or Items 23a or 28a-f show or other traumatic event, the Medical Examinar must be notified at	by Funeral Director	3 Xidowed 4 □ Divorced Specify: Specif	e - American Indian, k, White, etc. :: White
21215-0036	ithin 72 ho ne. nen "natur Nedical	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Bu	isiness/Industry
	filed with Hygiene other tha			
Maryland	2 should be f and Mental k is marked of aumatic ever	To Be	William Callanath	
Mar	and 2 sho ealth and n 27 is m		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Betty Burbage 6722 Libertytown RD Berlin, MD 2	State, Zip Code)
ore,	es 1 and 2 of Health If item 27 or other tra		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location -	City or Town, State
Baltimore,	Pa mer ury		'4 □Donation 5 □Other (Specify) Maryland Veterans Cem. Hurloc	
Ba	permit. Departi Import any nj		21. Signature of Fur al Service Licensee 22. Name and Address of Familia Burbage Funera 108 William St. Berlin, MD 21811	l Home
	Pnysician /Medical		23a. Part . Enter the disease for complications that daused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or field frailure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Dee to (or as a consequence of): Sequentially list conditions	Approximate Interval Between Onset and Death
	Examiner	i i	Sequentially list conditions, if any leading to immediate b. Due to (or as a consequence of):	teur
	acuted ind transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):	
3760,	eath certificate be executed attending physician and for use as the burial-transit	Ical Ex		
9	rtificate ng phy as the			
O. Box	0 0	Physician/Med	23c. If yes, outcome of pregnancy 1	e of delivery hth Day Year
rds, P.	The law requires that the ste has been signed by th page 2 should be detache	by	Part II. Other significant continuous contributing to death out not resulting in the underlying cause given in Part I.	ibute to the cause of death? 3 Probably 4 Unknown
Il Record		Completed	24a. Was an autopsy performed 2 1 Yes 30 No 1	Vere autopsy findings available rior to completion of cause of leath? Yes 2 \(\sum \) No
Vital	Physiclan: Th this certificate ral director, pag	o Be	examiner?	(0
of	ding Phys n. After this funeral di	H .		
Division	Attending It death. ector: After	catic	2 Accident investigation 2 Accident investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number	er or Rural Route Number
Σ	tal or Attences after death	Certification:	4 Homicide determined determined building, etc. (Specify)	" of Marar Mosto Montpol,
	To the Hospital or Attending Phwithin 24 hours after death. To the Funeral Director: After the completely filled in by the funeral	Medical		nner as stated. and due to the cause(s)
	To the within: To the comple	M	29b. Signature about the of confiner 29d. Date signed DD 8269 1000	(Month, Day, Year)
2.1	H, 2		60. Native and address of person who completed cause of death (Item 23a) (Type, Print) 1269 Cexastal Nightwo	19944
	Sta Registr		ALGALI VI ZIIIIZI ACA	

			For State Registrar	State of	Maryland /		rtment of F			-	giene Reg. Not	3001	36807
Г		2	Decedent's Name (First, Middle, La	ist)						2. Date of De	ath	•	3. Time of Death
	Physicia /Medic		John C. Mason							Month Octobe:	Day r 29	Year 2004	5:40 A M
	Examin		4a. Facility Name (If not institution, given	re street and numb	er)		4b. City, Town, o	r Location	of Death			County of Death	
₽			Casey House	7	A //		Rockvil		OA Hro			ontgomer	
r	Funeral Director			Sex 7. 1 ☑ M 2 ☐ F	Age (In yrs. last I	Yrs.	Months Days	Hours	Min.	8. Date of Bir (Month, Da 08/22/	y, Year)	Cour	
	ס		Usual Residence of Decedent		04					06/22/	1920	west	Virginia
	anylan show	_	10a. State 10b. County		10c. City, To							1	0d. Inside City Limits
	Ba-f	ecto	MD Montgome	ry	Rock	vill.	1			· · · · · · · · · · · · · · · · · · ·			1 ☐ Yes 2X No
	with the	Dir	10e. Street and Number				10f. Zip Code				•	zen of What Cour	itry?
	leath ns 23	erai	14346 Chesterfie	12. Was Decede	ent Ever in U.S.	13. V	20853 Vas Decedent of H	lispanic Ori	iain? (Spec	city Yes or No		S.A.	an Indian.
9	after o	Fun	1 ☐ Never Married 2 🏋 Married	Armed Force 1 [X] Yes 2 If Yes, Give		1	Yes, specify Cuba	an, Mexicar	n, Puerto F	Rican, etc.)		Black, White,	etc.
003	72 hours after death with the Maryland natural', or Items 23e or 28a-f show deal Exam net must be codiffed at	d by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Date	s: 1940–4.	5	Yes 2X No	Specify:				Specify: Wh	ite
5-("natu	iete	15. Decedent's E (Specify only highest gr	ducation a <i>d</i> e com <i>pleted)</i>	16	(Give	ent's Usual Occup	during mos	t of workin	g	16b. Kîr	nd of Business/In	dustry
12	withir ene. than	dmo	Elementary/Secondary (0-12)	College (1-4 4+		Atto:	00 NOT use retired rnev	<i>a)</i>			Lav	NJ	
0	filed Hygi other ent, I	e C	17. Father's Name (First, Middle, Las	<u>.</u>	1			18. Mothe	ər's Name	(First, Middle,			
lan	uld be fental rked c	O B	Camedo Masano					Gerv	vaise	Sluss			
Baltimore, Maryland 21215-0036	2 shou and N is ma		19a. Informant's Name/Relationship	Type, Print)			g Address (Street						
Σ.	and and m 27 m 27		Denise E. Mason,	Spouse		_	Chesteri	field		-			
ore	ges 1		20a. Method of Disposition 1 ☐ Burial 2 ⚠ Cremation 3 [Removal from Sta	ate ceme	tery, cren	sition (Name of natory or other place	· 1		ate	20c. Loc	cation - City or To	wn, State
ţ	t. Partmen		'4 □Donation 5 □Other (Special		Ft. L		1n Crema	-				twood, M	aryland
Ba	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23e or 28a-1 show any injury or other traumatic event, the Medical Exam per multipe notified at one.		21. Signature of Fundral Service Life	with M	veidy		Name and Addre		. 9	imple T			and 20852
	*		23a. Part1. Enter the disease, or con shock, or heart failure. List only	plications that cau one cause on eac	sed the death. Do	o not ente	er the mode of dyin	ng, such as	cardiac or	respiratory ar	rest,	1	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition resulting in death)	aPosti	nflammat	ory 1	Pulmonary	y Fibi	rosis				Onset and Death
	/Medical Examiner		resulting in death)	Due to (or	as a consequenc	e of):							
		<u>-</u>	Sequentially list conditions, if any, leading to immediate	b. — Due to (or	as a consequenc	e of):							
	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events										
oʻ	exec an an	Еха	resulting in death) Last	Due to (or	as a consequenc	e of);							
8760,	icate be executed physician and s the burial-transit	dical		d									
9	ertifica ling ph e as t	Med	IF FEMALE:	22 1									
Вох	The law requires that the death certificate has been signed by the attending page 2 should be detached for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months?		me of pregnancy n = 2 ∏Fetal dea t at time of death		Ectopic pregnancy	,			2	3d. Date of delive Month	ry Day Year
o.	that the de ed by the a detached t	ysic	1 □ Yes 2 □ No 9 □ Unknown	9 Unknow		3	Other (specify)						
<u>α</u>	signed by	by Pr	Part II. Other significant conditions	contributing to deat	h but not resulting	in the ur	derlying cause give	en in Part I.		23e. Did to	bacco us	se contribute to th	e cause of death?
Records,	w requires been sign should be	ed b								1 🗆 ነ	′es 2 🗆]No 3□Prob	ably 4 X Unknown
000	aw requas been 2 should	Completed								24a. Was		24b. Were auto	psy findings available
		Com									rmed? 2X No	death?	npletion of cause of 2 No
Vital	nysician: Th iis certificate director, pag	Be (25. Was case referred to medical examiner?						of Death	(Check only o			
of	Phys this al dii	D 1	1 ☐ Yes 2 👿 No 27. Manner of Death	Hospital: 1 Inp				4 🗀 190					Hospice
חס	ding Ph h. After th funeral	tion	1 XNatural 5 ☐ Pending		Day Year)	. Time of Injury	28c. Injun Worl	yat k? Yes 2 🔲 I		3d. Describe h	iow injury	occurred	
Division	r Attending Physician: er death. rector: After this certific by the funeral director.	fica	3 Suicide 6 Could not b	e 28e. Place of	Injury - At home,	farm, stre		.00 20		Bf. Location (S	treet and	Number or Rura	I Route Number,
Ē		Certification:	4 Homicide	building	, etc. (Specify)					City or Tow	m, State)		
	To the Hospital or Attending I within 24 hours after death. To the Suneral Director: After completely filled in by the funer	edicai (29a. Certifier 1 Certifying Pl (Check only one) 2 Medical Exa	nysician: To the be miner: On the basi and manner	s of examination a	ge, death and/or inv	occurred at the tin estigation, in my o	ne, date an pinion, dea	d place, ar th occurred	nd due to the d d at the time, d	ause(s) a date and p	and manner as st place, and due to	ated. the cause(s)
	To the within 2 To the complet	Me	29b. Signature and life of continer	M			29c. License	e number			29d. Date	signed (Month, I	Jay, Year)
			CATA	The		_		41	218		10	1201	04
	105	,	30. Name and address of person who									1-1/	- 1
	114		Charles Harrison			ster	Mill Roa	ad, Ro	ockvi	11e, Ma	aryla	ınd	
	Sta Registr	0	31. Date filed (Month, Day, Year) NOV 0 4 20		istrar's Signature	9	Sparks						

N A	A. MON	iK	1 - Stata Unpend Item	23a,27,2						-		004	36808	
	Dhamini		1. Decedent's Name (First, Middle,	-						2. Date of De		Year	3. Time of Death	
	Physicia /Medic		Brian Alan Mor	ık						NOV.	12, 2	2004	1645 P ^M	
	Examin	er	4a. Facility Name (If not institution, SHADY GROVE ADV	ENTIST HO	SPITAL		ROC	KVIL			MC	OUNTGOME!		
	Funeral Director		215-90-2667	6. Sex tx∑xM 2□F	7. Age (In yrs. la	33 Yrs.	If Under 1 Months	Year Days	Hours Min.		av. Year)	9. Birthp Cour 1 Mary	lace (State or Foreign ntry) land	
d K. I.S. I.S. 10000 filed within 72 hours after death with the Maryland	fied at	tor	Usual Residence of Decedent 10a. State 10b. County Maryland Montgo	omerv		Town or Lo						1	0d. Inside City Limits 1 □XYes 2 □ No	
h the	r 28e	irec	10e. Street and Number	, more y	1100	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	10f. Zip C	Code			10g. Citizer	n of What Coun	ntry?	
th wit	23a o	Funeral Director	629 Lincoln S	Street			20	850			US	SA		
r dea	ems M Tal	ner	11. Marital Status	12. Was Dece Armed For	dent Ever in U.S	5. 13.	Was Decede If Yes, specif	nt of Hisp y Cuban,	oanic Origin? (S Mexican, Puert	pecify Yes or No to Rican, etc.)	- 14.	. Race - Americ Black, White,		
ours afte	piene. Ir than "natural", or Items 23a or 28e-f show It e Mudical Examinat cuast be multind at	by	12∑ Never Married 2 ☐ Marrie 3 ☐ Widowed 4 ☐ Divorced	ed 1 ☐ Yes If Yes, Giv Year or Da	0		1⊡Yes 2∜a	□ No	Specify:		Sp	pecify: Whi	te	
15.13	e. "natu	Completed	15. Decedent' (Specify only highest Elementary/Secondary (0-12)		-4or 5+)	(Give	dent's Usual kind of work DO NOT use	done du	ion ring most of woi	rking	16b, Kind	of Business/Inc	dustry	
ed K	har th		10			Car	penter		O Markharla Mar	- / Cinch Bainful			ruction	
2 2	d d	Be	17. Father's Name (First, Middle, L Clarence J. Mo					'		ne (First, Middle	, Maiden Su	imame)		
should	nd Mental Hygiene. marked othar than matic evant, it e M	ဥ	19a. Informant's Name/Relationsh			19b. Mailir	na Address (Street an	Mary d Number or Ru	ıral Route Numb	er. City or To	own. State. Zip	Code)	
-	G 00 3		Mary J. Anderso							Rockvill				
S 1 a	of Health Itam 27 I		20a. Method of Disposition	· · · · · · · · · · · · · · · · · · ·	Ce	ace of Dispo	sition (Name	e of er place)		Date ember 17		tion - City or To	wn, State	
Pages	nent e		1 ☑ Burial 2 ☐ Cremation 14 ☐ Donation 5 ☐ Other (Sp		State	Gate o	f Ĥeav	ren	11006		Silver	r Sprin	g, Maryland	
Dariii Pages	Department of I	21. Signature of Funeral Service Licensee 22. Name and Francis							Address of Facility. **Collins Funeral Home inc					
<u> </u>	0599	1000	Nobert 10	1/4/4	-				versity Blvd, W, Silver Spring, MD 2090 of dying, such as cardiac or respiratory arrest, Approximate Interval Between					
1	nysician Medical xaminer		Immediate Cause (Final disease or condition resulting in death)	a. Narcot Due to (cic Into	ence of):		, ,					Interval Between Onset and Death	
oo/ou,	physician and the burial-transit	edicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause, Disease or injury that initiated events resulting in death) Last	с.	or as a consequ								().	
Geath cert	atter for u	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 ☐ Live b	come of pregnar irth 2 Fetal ant at time of de	death 3	⊒Ectopic preç] Other (spec				230	d. Date of delive Month	ory Day Year	
ords, F.O.	been signed by the s should be detached	by	Part II. Other significant condition	ns contributing to de	eath but not resu	lting in the u	nderlying cau	use given	in Part I.		obacco use Yes 2 🗆 N		ne cause of death?	
T Ge law	S C .	ompleted										prior to cor death?	psy findings available πpletion of cause of 2 No	
	rtifica Stor, p	Be C	25. Was case referred to medical examiner?						26. Place of Dea	ath (Check only		74.4		
Of VITA	his certific I director,	To	examiner? 1 X Yes 2 □ No	Hospital: 1 □ I	npatient 2XX	ER/Outpatier	nt 3 DOA	Other	4 Nursing H	lome 5 🗆 Resi	dence 6	Other (Specify	1)	
SION C	ith. :: After this e funeral di	ation:	27. Manner of Death 1 Natural 2 Accident		Day Year)	Found:	• м	c. Injury a Work? 1 🗀 Ye		28d. Describe	how injury o	ccurred UNK		
DIVIS	within 24 hours after death. To tha Funarel Diractor: After completely filled in by the fune	Certification:	3 ☐ Suicide 6 🖫 Could n 4 ☐ Homicide determi	Duitali	of Injury - At hongs, etc. (Specify))		office		28f. Location (City or To	Street and N wn, State)	17658 T , Maryl	owncrest Dr	
Hospita	24 hours after of a Funarel Dirac letely filled in by	ledical C	29a. Certifier 1 Certifying (Check only one) Medical E	Physician: To the Examiner: On the ba	best of my know	vledge, deat	h occurred at	t the time	, date and place nion, death occu	, and due to the	cause(s) an	id manner as st	ated.	
To the	within To the comple	Med	29b. Signature and title of certifier	elah 4				License O.C.			29d. Date s	signed (Month,		
/	(D)		30 Name and address of person y	who completed caus	e of death (Item	1 Peni	Print) n Stre	et.	Baltimo	re, Mar	/land	21201		
	Sta Registi		31. Date filed (Month, Day, Year)	32 R	egistrar's Signat	ure 4	Love							
		1	1104 7 0 1				8		/					

State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) NOVEMBER 3 **Physician** GERSON MUSSI MACHADO 2004 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner LA PLATA CIVISTA MEDICAL CENTER CHARLES If Under 24 Hrs. 8. Date of Birth
Hours Min. (Month, Day, 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1**∑**M 2□F 56 NONE Yrs. Director DEC 31 1947 BRAZIÍ Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Haaith and Mental Hygiene. Important: If Item 27 is marked other then "naturel", or Items 23e or 28e-1 ehow any injury or other treumatic event, Ite Medical Examples. 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits 1 ¥ Yes 2 □ No Director Waldorf Maryland Charles 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20603 **Brazil** 6211 Deerwood Court Be Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 ☐ Married 1XIYes 2□No Specify: Brazillian Specify: White 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Ammunition Elementary/Secondary (0-12) College (1-4or 5+) Laborer Factory 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Moacyr Machado Argelina Mussi Machado 19a. Informant's Name/Relationship (Type, Print) (Sister) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Debora Mussi M. Mascarenhas 6211 Deerwood Court Waldorf, MD 20601 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Buria 12 Cremation 3 ☐ Removal from State * 4 □ Donation 5 □ Other (Specify) Metropolitan Crematory 11-6-04 Alexandria, VA 21. Signature of Fundral Service Licenses 22. Name and Address of Facility Eberwein Funeral Services M00173 4433 White Pls., La., White Pls., MD 20695 ven Poil. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, lock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pnysician RENAL FAILURE 6 MONTHS /Medical Due to (or as a consequence of): **Examiner** HYPERTENSION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner to the Hospitel or Attending Physician: The law requires that the death certificate be executed burial-transit DIABETES Due to (or as a consequence of): Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 3 Ectopic pregnancy 2 Fetal death Month Day 4☐Pregnant at time of death 5 Other (specify) P.0. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, SEPSIS 1 Yes 2 No 3 Probably 4 Unknown PERICARDITIS 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2□ No 2 X No 1 Tyes 1 Yes Division of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2X No 1X Inpatient 2 ER/Outpatient 3□ DOA Certification; To After this 28b. Time of 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1X Natural s after dea. 1 ☐ Yes 2 ☐ No M 2 Accident 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a

To the Funerel D

completely filled in X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier. D 28281 11/05 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Nelson V. Benjers, M.D. 9131 Piscataway Rd. #600 Clinton, MD 20735 31. Date filed (Month, Day, Year) State NOV 0 5 2004 Registrar

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygie 20 0 4 1 - For State Registral Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician JASMINE** Month MOWATT November 2004 11:58 A^M /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Washington Adventist Hospital Takoma Park

If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. Montgomery 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Birthplace (State or Foreign Country) 1 M 2 F Director 212.64.7621 62 Yrs. 2, 1942 Jan. Jamaica, W.I. Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: if item 27 is marked other then "natural; or items 23e or 28e-1 show any injury or other treumetic event, the Medical Exemplest Trust by modified at once. 10a. State 10c. City, Town or Location 10d. Inside City Limits Directo Maryland Prince George's 1X Yes 2 ☐ No Hyattsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5904 Chillumgate Road 20782 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No δ Specify: Specify: Black 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Compl College (1-4or 5+) Elementary/Secondary (0-12) 12th Cook Catholic University 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be David Mowatt Inez Davidson ပ္ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Felicia Thompson/Sister 5904 Chillumgate Road, Hyattsville, Maryland 20782 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Gate Of Heaven Ceme. 11/13/2004 Silver Spring, Maryland * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee HINES-RINALDI FUNERAL HOME INC. Na 11800 New Hampshire Ave, Silver Spring, MD 20904 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heer failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Priysician disease or condition resulting in death) Due to (a) as a consequence of): 24 WS Jusion /Medical Examiner 3 + year) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events work Due to (or as a consequence of): Examiner sician and burial-transit Per Verbal (D. Barband) Accentrable For 23A(A) Division of Vital Records, P.O. Box 68760. resulting in death) Last Due to (or as a consequence of) attending physician for use as the buria Physician/Medical the IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Cher (specify) 1 ☐ Yes 2 No the i 9 Unknown 9 Unknown ģ s been signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Vasca 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed' certificate 1 Yes 2 No director. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner's Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this After th 27. Manner of Death 28a. Dale of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred Hospital or Attending 17 Natural 2 Accident 5 Pending death. investigation 1 ☐ Yes 2 ☐ No Director: / 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Thomicide 24 hours a Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) ပ္ 29c. License number Nor 2, 2004 war 4D D26265 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Arc#350 Takoma JAIME F. MARQUEZ HD. Carroll 7610 31. Date filod (Month, Day, Year) 32. Registrar's Signature State NOV 0 5 2004 Registrar

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236-84-7747 91 10 c. Street of December		Ģ		Sex 7. Age (In yrs	s. last birthday) If Ur	nder 1 Year If U		8. Date of Bi	rth		
The property of the property o	D		Usual Residence of Decedent	91	Yrs.			June 1	15, 19	13 West	t Virginia
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Examin Funeral Director		4a. Facility Name (If not institution, give street and number) St. Mary's Hospital 5. Social Security Number 6. Sex 7. Age (In yrs. las 1	st birthday) _ Yrs.	4b. City, Town, or I Leonardto If Under 1 Year Months Days	Wn If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Feb. 19,	rear)	
aryland show	J.		Town or Loc	cation				10d. Inside City Limits
n with the M 3a or 28a-f	Direc	Maryland St. Mary's Leonar 10e. Street and Number 22680 Cedar Lane Court, Apt. 3407	dtown	10f. Zip Code 20650			Og. Citizen of Wha	1 🖫 Yes 2 🗆 No
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nd 2 should lith and 27 is m		19a. Informant's Name/Relationship (Type, Print) Catherine Cohan/Daughter	1241 Ba	g Address (Street ar	e, Owings,	<i>i Route Number,</i> Maryland	20736	
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The law ate has b page 2 sl	Completed					24a. Was an autopsy perform	prio	re autopsy findings available r to completion of cause of th? Yes 2 \(\text{No} \)
Attanding Physician: Thr death. ector: After this certificate by the funeral director, pag	ertification; To Be	27. Manner of Death 1 Natural 5 Pending (Month, Day Year) 2 Accident investigation 3 Suicide 5 Could not be	P/Outpatient 8b. Time of Injury	3 DOA Other 28c. Injury a Work? M 1 Ye	at 2 No	ne 5 🗌 Resider 28d. Describe how	nce 6 Other (
Hospital or Attandi 24 hours after death 5 Funeral Director: A stely filled in by the fr	O	4 Homicide determined 28e. Place of Injury - Ar nome building, etc. (Specify)			<u>w</u>	City or Town,	State)	or Rural Route Number,
To the Hospital or All within 24 hours after of To the Funeral Direct completely filled in by	Medical	29a. Certifier (Check only one) Certifying Physicien: To the best of my knowle (Check only one) Medical Examiner: On the basis of examination and manner stated. 29b. Signature and title of certifier	age, death	estigation, in my opi	nion, death occurre	ed at the time, da	te and place, and d. Date signed (M	due to the cause(s) fonth, Day, Year)
		30. Name and address of person who completed cause of death (Item 23 AVANI D SHAH PO BX 404 I.EONARD		²rint)	7066		11 2	- 9
Sta		31. Date filed (Month, Day, Year) 32. Registrar's Signature	- 15	111 20030	,			

CHARLES LLEWELLY MATTINGLY

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend item#23a-c PII 25 27 per ME 6837 11/17/04 TT
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2 () [] [... 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** MAY Morris 2004 1230 Landar /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Keninswa Regional Medical Center Solisburg Wicomies If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday, 5. Social Security Number 6 Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign
Country) **Funeral** 1**√** M 2□ F Months Days Hours Min. Vrs Director 81 unknown 218-76-0856 1923 March 4, Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a State 10h County 10d. Inside City Limits item 27 is marked other then *neturel', or items 23a or 28a-f show other traumatic event, the Modical Examiner must be notified at 1 Yes 2 □ No Director Salisbury Maryland Wicomico 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 21801 USA 105 Times Square 2 should be filed within 72 hours after death vin and Mental Hygiene.
Is marked other then "neturel", or items 23s Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 20 No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1

Never Married 2

Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Completed by Specify: 3 Widowed 4 Divorced Black 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Colfege (1-4or 5+) unknown unknown LIFTERENCHICAGO 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be unknown unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 st Department of Health and Important: If item 27 is n eny injury or other traun 105 Times Square, Salisbury, Maryland (friend) E. Thomas Sterling 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Pages 1 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State ' 4 ☐ Donation 5 ☐ Other (Specify) Salisbury Crematory May 13, 2004 Salisbury, Maryland 21. Signature of Funeral Service Licens Holloway Funeral Home Professional Association 501 Snow Hill Road, Salisbury, Maryland 21804 Kell Noune 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Intracranial hemorrhage Immediate Cause (Final Physician one days disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** PLEMONAY Sequentially list conditions, I any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of) Examiner burial-transit MRSA CERTIFICATION APPROVED BY MEDICAL EXAM Due to (or as a consequence of): attending physician P.O. Box 68760 Physician/Medical the IF FEMALE ase a 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐Ectopic pregnancy in the past 12 months? Day 4☐Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Pulmonary embolism, Pneumonia 1 Yes 2 PNo 3 Probably 4 Unknown Completed 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death? 2 No 2 No 1 Yes 1 TYes To the Hospitel or Attending Physicien: within 24 hours after death.

To the Funerel Director: After this certifica 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1X Yes 2 1 Inpatient 2 ER/Outpatient 3 DOA 2 Division of 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 🗀 Pending 1 ☐ Yes 2 ☐ No investigation 2 🗋 Accident 6 Could not be determined 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier cal (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) me de May 10 1 200 4 DO51359 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) USHA NATESAN ST, SALISBURY MD 21804 DIVISION 5. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAY 1 3 2004 Registrar

			1 - Statemend Item 25 Registrar	State of M per ME,G	1aryland 137,11	/18 /8	ortment of H	ealth and i Death	Mental Hyg	giene 00L	+ 36814		
			1. Decedent's Name (First, Middle, La	st)					2. Date of Dea Month	ith Day Ye	3. Time of Death		
	Physicia /Medic		MARIO ROBERTO	MEDINA					JUNE	29 2004			
	Examin		4a. Facility Name (If not institution, give	re street and numbe	r)		4b. City, Town, or	Location of Death	1	4c. County of E	Death		
			5 MALLARD LANE	Sa. 1 7 7	ige (In yrs. la	-	KEEDYS	SVILLE If Under 24 Hrs.	Doto of Birth		SHINGTON		
	Funeral Director		5. Social Security Number 6. S 231-31-2986	1⊠M 2□F	37	Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day		Birthplace (State or Foreign Country) UATEMAT.A		
			Usual Residence of Decedent						وک ایالان	1900 G	UALEMALIA		
	rylan thow		10a. State 10b. County		10c. City,	Town or Lo	cation				10d. Inside City Limits		
	Be-f s	cto	MARYLAND WASHING	GTON				EDYSVILL	E		1 X Yes 2 □ No		
	vith th	Director	10e. Street and Number				10f. Zip Code			10g. Citizen of Wha	t Country?		
	s 236	Funeral	5 MALLARD LANE	12. Was Deceden	t Ever in 11 S	12.1	Vas Decedent of His	756	nooity Voc or No	GUATE	MALA American Indian,		
	ter de	Š	11. Marital Status 1 ☑ Never Married 2 ☐ Married	Amed Forces	3?	. 13.	f Yes, specify Cubar	n, Mexican, Puert	o Rican, etc.)		White, etc.		
98	ours after death with the Marylan rel', or Items 23e or 28e-f show Examinar must be notified at	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates			1 X Yes 2 □ No	Specify: Gua	temala	Specify:	HISPANIC		
5-0	72 hours after death with the Maryland neturel', or Items 23e or 28e-f show dical Exantiner must be notified at	Completed	15. Decedent's E (Specify only highest gra				dent's Usual Occupa kind of work done di		kina	16b. Kind of Busine			
7	I within 72 ho iene. r than "netui the Medical	ם	Elementary/Secondary (0-12)	College (1-4o	r 5+)	life. I	DO NOT use retired)		9				
121			17. Father's Name (First, Middle, Last	1			HANDICAPI		no /Eiret Middle		DICAPPED		
Maryland 21215-0036	be do do) Be	MARIO MEDINA	/					lame (First, Middle, Maiden Sumame) JA BARILLAS				
Z	₹ p E E	ဥ	19a. Informant's Name/Relationship (Type, Print)	-	19b. Mailir	ng Address (Street a				e, Zip Code)		
	1 and 2 s Health ar tem 27 ie		GUISELLA WITHERS	/MOTHER			LLARD LANI				21756		
Baltimore,	iges 1 a nt of Hei : If item or othe		20a. Method of Disposition	70 11 000	20b. Pla			20c. Location - City	or Town, State				
Ĕ	Par Fr		1 ⊠ Burial 2 □ Cremation 3 ∑ 1 □ Cremation 3 □ Other (Special Special		θ		CEMETERY	1	1/2004 K	EEDYSVILI	E. MARYLAND		
alt	permit. Pag Department Important: any injury c		21. Signature of Juneral Service Lice		M DE		s of Facility		d Nationa				
_	205 20		Cull-KA	au PAUL	L HOME		ro, Maryl						
			23a. Pan 1. Enter the disease, or com- shock, or heart failure. List only	one cause on each	ed the death. line.	Do not ent	er the mode of dying	, such as cardiac	or respiratory arr	est,	Approximate Interval Between Onset and Death		
	Physician		Immediate Cause (Final disease or condition resulting in death)	aA	Sphy	XXI					10 hrs		
	/Medical Examiner		Tooling in doding	Due to (or a	consedue	ence of):	Disord	11.		14 /	000		
		er	Sequentially list conditions, if any, leading to immediate	b. Due to (or a	s a conseque	ence of):	DISOLEC		V	1. 16-16	myears		
	d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	C				1 hu	PROVED BY MEDIC	AL EXAMINE!			
oʻ	te be executed ysician and te burial-transit	Exa	resulting in death) Last	Due to (or a	s a conseque	ence of):		THE CATION AP	PROVE				
8760,	cate be executed physician and the burial-transit	dlcal	,	d				GEKIN					
w.		Mec	IF FEMALE:	020 16									
Вох	death certific e attending p id for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcom 1☐Live birth 4☐Pregnant	2 🗌 Fetal o	teath 3	Ectopic pregnancy Other (specify)			23d. Date of Month	delivery Day Year		
o.	0 0 0	yslo	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown	at time or dea	iii 5_	Other (specify)						
Ω.,	g p g		Part II. Other significent conditions	contributing to death	but not result	ting in the ur	nderlying cause give	n in Part I.	23e. Did tot	bacco use contribut	e to the cause of death?		
of Vital Records,	n signe	ed by	Cons	enital	her	nop	mila		1 □ Ye	es 2 No 3 □	Probably 4 Unknown		
၀	aw requir s been si 2 should	Completed	Des	cuisal	me /	x1+	tarti		24a. Was a		autopsy findings available		
Ä	The lav	mo;				autops perform	ned? death	to completion of cause of 1? ∕es 2 □ No					
ita	sicien: Th certificate rector, pag	ВеС	25. Was case relerred to medical examiner?			th (Check only on	,						
× ×	Phyaician: this certific ral director.	2	1 Yes - 2 No	Hospital: 1 ☐ Inpa			ence 6 Other (5	Specify)					
u C	ling After une	on	27. Manner of Death ↑ Autural 5 ☐ Pending	28a. Date of In (Month, D	Jury Pay Year)	28b. Time of Injury	Work'		28d. Describe ho	ow injury occurred			
Division	Attending r death. ector: After by the fune	icat	2 Accident investigatio 3 Suicide 6 Could not b	OP Place of I	niury - At hon	ne larm str	M 1 ☐ Y eet, factory, office	es 2 □No	28f. Location (St	treet and Number or	Rural Route Number,		
Ö		Certification:	4 Homicide determined	building,	etc. (Specify)		out, lastery, omos		City or Town		,		
	To the Hospitel or within 24 hours after To the Funerel Dir completely filled in		29a. Certifier Certifying Pr	ysician: To the bes	t of my know	ledge, death	occurred at the time	a, date and place,	and due to the ca	ause(s) and manner	as stated.		
	in 24 the Fu	Medical	(Check only 2 Medical Exer	miner: On the basis and manner:	ot examinationstated.	on and/or inv	estigation, in my opi	nion, death occur					
	To the within 2. To the complet	Σ	29b. Signature and title of certifier	}	7		29c. License	14499	16 2	9d. Date signed (Mo	onth, Day, Year)		
	4		P (- ()					, , , , ,		june 27,			
r			30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print) Lamans Rd Branchow MD 217).										
)K´		Lalax	Malik	MD	202	11 Lappan	rs Red	Beanse	5000 M	0 217/3		
	Sta	te	31. Date liled (Month, Day, Year)	Malik	trar's Signatu	103	il lappar	rs (Led	BEANSE	5000 M	0 21713		

				partment of Health and Mertificate of Death	lental Hygie Reg.	2004 36815		
			Decedent's Name (First, Middle, Last)		2. Date of Death	3. Time of Death		
	Physici /Medic		Alice S. McKinney			Day Year 0310 A ^M		
}	Examir		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death		
			Chester River Hospital	Chestertown		Kent		
	Funeral Director		5. Social Security Number 6. Sex 1 M 2X F 7. Age (In yrs. last birthday) 7. Age (In yrs. last birthday) 7. Age (In yrs. last birthday) 7. Age (In yrs. last birthday) 7. Age (In yrs. last birthday)	y) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Ye Jan 04 19	Birth 9. Birthplace (State or Foreign Country) 4. 1925 Maryland		
	pu ,		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or	Location				
	anyla	2				10d. Inside City Limits 1 ☐ Yes 2 📉 No		
	hе М	ecto	Maryland Queen Anne Barcl		10-	Citizen of What Country?		
	a or	ä		10f. Zip Code	iog.	,		
	eath	era	917 Dixon Tavern Road 11. Marital Status 12. Was Decedent Ever in U.S. 15.	21607 Nas Decedent of Hispanic Origin? (Spe	acify Yes or No-	USA 14. Race - American Indian,		
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "netural", or Items 23s or 28s-1 show any injury or other traumatic event; if a Marical Event is at russ be notified at anone.	by Funeral Director	Armed Forces? 1 Never Married 2 Married 1 Yes 2 No If Yes, Give 3 No Widowed 4 Divorced Year or Dates:	B. Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 No Specify:	Rican, etc.)	Black, White, etc. Specify: White		
Š	2 hor	ted		edent's Usual Occupation	166	b. Kind of Business/Industry		
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nd	be fill d oth evan	Be	17. Father's Name (First, Middle, Last)		(First, Middle, Maid	,		
yla	ould I Men varka vatic	2	Clarence D. Seward			olden Seward		
Maryland	12 sh h and 7 la n traun			iling Address (Street and Number or Rura				
	1 and Healt am 2 thar			O Box 581 Greensbor		and 21639 Location - City or Town, State		
10	Pages nent of P ant: If its ary or of		1 XBurial 2 ☐ Cremation 3 ☐ Removal from State cemetery, c	ematory or other place)				
Baltimore,	artme ortan injury		`4 □ Donation 5 □ Other (Specify) Busick 21. Signature of Funeral Service Licensee	Church Cem 11/06 22. Name and Address of Facility	1/U4 Da	arclay, Maryland		
B	Deparimon Deparement Important Impor		It and Colon	Fleesle 180d GREENSBO	gin Eurer	ral Home, PA		
	Physician		23a. Part 1. Enter the disease, or complications that caused the death. Do not a shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition)			Approximate Interval Between Onset and Death		
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	sit sit	Examiner	Due to for as a consequence of cause. Enter funderlying Cause (Disease or injury					
	cate be executed physician and the burial-transit	хап	that initiated events resulting in death) Last C. Due to (or as a consequence of):					
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687		edical	d					
.O. Box	Physician: The law requires that the death certific this certificate has been signed by the attending rail director, page 2 should be detached for use as	Physician/Me		□ Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Day Year		
₽	es that igned by be deta	by Ph	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacc	co use contribute to the cause of death?		
rds,	quires n sign		DPnaimonia		1 🗆 Yes	2 ₱No 3 Probably 4 Unknown		
Record	s been s	Completed	E) Panciertie mass		24a. Was an	24b. Were autopsy findings available		
Re	The lav te has age 2	mo	3) DM. Ting I		autopsy performed 1 ☐ Yes 2 ☑	prior to completion of cause of death? No 1 Yes 2 No		
Vital	ician: Th certificate rector, pag	O	25. Was case referred of edical	26. Place of Death		NO 10 10 105 20 NO		
f <	nyaich nis ce direc	To B	examiner? 1 Yes 2 No Hospital: 1 Impatient 2 ER/Outpat	ent 3 DOA Other: 4 Nursing Hon	ne 5 Residence	e 6 ☐Other (Specify)		
n of	ding Ph		27. Manner of Death 1 12 Patural 5 Pending 28a. Date of Injury (Month, Day Year) 28b. Time (Injury)	Work?	28d. Describe how in	njury occurred		
sio	tandi leath tor: A	cati	2 Accident investigation 3 Suicide 6 Could not be	M 1 Yes 2 No	201 1 12 12			
Division	ital or Al rs after c al Dirac led in by	Certification:	4 Homicide determined 288. Place of Injury - At norms, farm, building, etc. (Specify)		City or Town, St			
	To the Hospital or Attending Physicien: The I within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Medical	29a. Certifier (Check only one) 1	ath occurred at the time, date and place, a investigation, in my opinion, death occurre	and due to the cause ad at the time, date	e(s) and manner as stated. and place, and due to the cause(s)		
)	To To	2	29b. Signature and title of certifier 1191. When , M.D.	29c. License number 23 23 13		Date signed (Month, Day, Year)		
_			30. Name and address of person who completed cause of death (Item 23a) (Typ KIN K. WUN , 415 Wishingto	o, Print) m Ave., Chestert	own, n	1D 21620		
	Sta Registr		31. Date filed (Month, Day, Year) 32. Registrar's Signature (Month, Day, Year)	Ave., Clester				

∧ T	N MOOLL) <u>C</u> il\	1 - For Stata Registrar	State of Maryland		artment of Hertificate of L		Mental Hygi	ene g. No. 2004	36816
	Physici	an	1. Decedent's Name (First, Middle, Las					2. Date of Death Month	Day Year	3. Time of Death
	/Medio Examir		Kevin L 4a. Facility Name (If not institution, give UNIVERSITY HOSE	o. Moulden e street and number) PITAL		4b. City, Town, or BALTIN	Location of Death		31, 2004 4c. County of Death None	1
	Funeral Director		5. Social Security Number 6. S 218-06-4485	ex 7. Age (In yrs. last	birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, July 24	Year) Cour	place (State or Foreign htry) Yland
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If Item 27 Is marked other than "natural; or items 23s or 28s-f show any injury or other traumatic event, I'm Medical Evans extrnust be notified at once.	To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State 10b. County Maryland Anne A 10e. Street and Number 11 Bens Drive 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12) 10th 17. Father's Name (First, Middle, Last) Kenneth L. 19a. Informant's Name/Relationship (Apt. E 12. Was Decedent Ever in U.S. Amed Forces? 1	13. l	Lis 10f. Zip Code 21403 Was Decedent of His f Yes, specify Cubar 1 Yes 2 X No dent's Usual Occupa kind of work done do DO NOT use retired) COOK	n, Mexican, Puerto Specify: tion uring most of worn 18. Mother's Nam Kal	becify Yes or No- p Rican, etc.) king 1 the (First, Middle, Moren Grav	Ig. Citizen of What Cour USA 14. Race - Americ Black, White, Specify: B1 6b. Kind of Business/Inc ARINC Co.	can Indian, etc. a C k dustry
Baltimore, M	permit. Pages 1 and 2 Department of Health Important: If Itam 27 any injury or other tro		Karen Graves (No. 20a. Method of Disposition 12 Squarial 2 Cremation 3 Squarial 2 Control (Specification 21. Signature of Funeral Service Licer	Removal from State 20b. Place cert Best Park	of Dispo etery, crer gate	sition (Name of natory or other place) Memori Name and Address Reese	a1 11/6 s of Facility & Sons	Date 2 5/04 A 5 Mortua	oolis, Md. Oc. Location - City or To Annapolis, Ary. P.A. Md. 2140	own, State Md •
68760,	Medical Examiner buly sician and physician and presented step physician and step physicia	ai Examiner	23a. Part1. Enter the disease, or come shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate sauch. Set of conditions cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequent co	STeffs ce of): ce of):		, such as cardiac	or respiratory arre	st,	Approximate Interval Between Onset and Death
P.O. Box	es that the death certif gned by the attending be detached for use a	ed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown Part II. Dther significant conditions of	. d. 23c. If yes, outcome of pregnancy 1	ath 3[Ectopic pregnancy Other (specify) nderlying cause give	n in Part I.	23e. Did toba	23d. Date of deliver Month acco use contribute to the contribute	Day Year
Division of Vital Records,	To the Hospital or Attanding Physician: The law requir within 24 hours after death. To the Funeral Diractor: After this certificate has been si completely filled in by the funeral director, page 2 should	Medical Certification: To Be Completed	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigation 3 Suicide 4 Homicide Check only one 29a. Certifier (Check only one) 29b. Signature and title of certifier 30. Name and address of person with	28a. Date of Injury (Month, Day Year) 19 28a. Place of Injury - At home building, etc. (Specify) 28 ysician: To the best of my knowled inter: On the basis of examination and manner stated.	dge, death and/or in	28c. Injury Work 1 Y eet, factory, office Coccurred at the time restigation, in my op 29c. License	e, date and place, inion, death occur	th (Check only one) th (Check only one) th (Check only one) Small Resider 28d. Describe hov SußTC 28f. Location (Strectly or Town, ANN PG and due to the cau red at the time, dat	prior to cordeaths? No 12 Yes Dice 6 Other (Specify vinjury occurred TWAS State) 123 3 Gwn Use(s) and manner as st	I Route Number, AN DY:VE
	Sta		SACK W. Ti	tus, M.D. 11 32. Refistrar's Signature	1 Per	n Street	, Baltimo	ore, Mary	land 21201	
	Regist	ar	NOV - 3	2004	-	-				

1-	For State Registra
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Certificate of Death

Reg. No. U D Ls

Physician /Medical Examiner

Funeral Director

iled within 72 hours after death with the Maryland itam 27 is marked other than "netural", or Itams 23a or 28e-1 show other traumatic event. If a Medical Examinat must be notified at al Hygiene. 12 should be fi and Mental H is marked ot

NAME KNOWN TO PHYSICIAN: DON W.

Baltimore, Maryland 21215-0036

permit, Page Department of Important: If any injury or once. Physician /Medical Examiner

Health am 27

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Pages jo 📜

The law requires that the death certificate be executed use as the burial-transit P.O. Division of Vital Records, 90 funeral director, page 2 should Hospitel or Attending Physician: this after death. filled in by the within 24 hours a To the Funarel D completely tha

1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Dav Year Don Walter Montz OCTOBER 2004 11:30P 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death VA MARYLAND HEALTH CARE SYSTEM PERRY POINT CECIL If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Dec. 12,1927 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 10XM 2□ F Vrs 76 AZ219-22-9952 Usual Residence of Decedent 10a State 10c. City, Town or Location 10h County 10d. Inside City Limits Completed by Funeral Director MD Anne Arundel 1 ☐ Yes 2 ☑ No Severn 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7959 Telegraph Road, Lot 100 21144 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠Yes 2 □ No 194 If Yes, Give Year or Dates: 194 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1945 1 ☐ Never Married 2 ☐ Married White 1 ☐ Yes 2 🔀 No Specify: Specify 1948 3 XWidowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Tractor Trailer Freight Driver Teamsters Union 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Walter Elies Montz Lillian G. Taylor 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Evelyn Helsel/Daughter 228 Cypress Creek Road, Severna Park, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State Nov. 3, 1 XBurial 2 Cremation 3 Removal from State Crownsville, MD MD Veterans Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 2004 21. Signature of Fungral Service Licensee Barranco & Sons, P.A. Severna Park Funeral Home 495 Gov. Ritchie Hwy, Severna Park, MD 21146 23a. Part Forter the seasy or complications that drused the death. In not enter the mode of dying, such as cardiac or respiratory arrest, show, or heart failure. List only one chuse on lach line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) PNUEMONIA UNKNOWN Due to (or as a consequence of): LARYNGEAL CARCINOMA UNKNOWN Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of injury) Due to (or as a consequence of): Examiner Cause (Disease of ways that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 Yes 2 No 3 Probably 4 Nunknown CORONARY ARTERY DISEASE, HYPERTENSION Completed 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 1 Yes 2 XNo Be (25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: Certification: To 1 ☐ Yes 2 X No 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 1 XNatural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 🗌 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Example 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier cai (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number D24648 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar DHMH 17 Rev 1/2001

State

SHER A. HASHMI, M.D.,

2004

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Registrar's Signature

VA MARYLAND HEALTH CARE SYSTEM, PERRY POINT, MD

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			1 - For State Registrar	State of M	•	tificate of			99. N 2 11 11	1 20010
			Hegistrar 1. Decedent's Name (First, Middle, Last)			tinoate of	Death	2. Date of Dea		3. Time of Death
	Physici			trick	Natale			Month	Day ER 14, 2	Year M
	/Medic Examir		4a. Facility Name (If not institution, give s			4b. City, Town, o	r Location of Dea		4c. County o	
			13800 BEDFORD ROAD			CUMBERL	AND		ALLEGA	NY
	Funeral		Social Security Number 6. Sex	M 2DE	ge (In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs Hours Min		Year)	Birthplace (State or Foreign Country) MD
	Director		214-46-2818	5	56 Yrs.			Mar 25,	1948	MD
	land w ti		10a. State 10b. County		10c. City, Town or Lo					10d. Inside City Limits
	Mary I-f sh	io	MD Allegany	1	LaVal	е				1, Yes 2 □ No
	h the	irec	10e. Street and Number			10f. Zip Code		1	l0g. Citizen of W	hat Country?
	th wil	by Funeral Director	944 1/2 Weires Ave	nue			21502		US	Α
	er des	nue		Was Decedent Armed Forces?	Ever in U.S. 13.	Was Decedent of F f Yes, specify Cuba	lispanic Origin? (: an, Mexican, Pue	Specify Yes or No- rto Rican, etc.)	14. Race Black	- American Indian, ;, White, etc.
36	rs after	J F	1 ☐ Never Married	1 Yes 2 If Yes, Give	1968-1987	1□Yes 2★ No	Specify:		Specify:	white
9	2 hou	ted	15. Decedent's Educ	ation		dent's Usual Occup	pation		16b, Kind of Bus	
21215-0036	within 72 hours after death with the Maryland ene. than "natural", or Itema 23e or 28a-f ehow ta Mezical Exactifier frant be notified at	Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or	5+)	dent's Usual Occup kind of work done DO NOT use retired	d) most of wo			
	filed with Hygiene. other than	ပ်	12		owner/	operator	40 Markada Na			Case Mang.
and	be fill ad oth even	Be	17. Father's Name (First, Middle, Last)	otolo				_{.me (First, Middle, I} .ouise Bak		•
Maryland	should be ind Mental s marked o	ပို	Herbert James N 19a. Informant's Name/Relationship (Ty)		19b Mailir	ng Address (Street		lura/Route Number		
Ma	C1 00 -= 00		Erlinda Natale	wife		1/2 Weire				MD 21502
ē,	s 1 and if Health item 27 other tr		20a. Method of Disposition		20b. Place of Dispo	sition (Name of	ce)	Date	20c. Location - C	City or Town, State
Ë	Pages nent of int: If it		1 ☑ Burial 2 ☐ Cremation 3 ☐ R '4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	Rocky Gap			11/18/2004	Flintstor	ne MD
Baltimore,	permit. Pages 1 and Department of Health Important: If item 27 any injury or other tr once		21. Signature of Funeral Service License)° \	1 1 1 1 22	Name and Address Scarpell	ss of Facility	lome PA		
_	89789		Ljamis	+ Dy	W'	108 Viro	inia Avenu	e: Cumberl:	and, MD 2	
			23a. Part1. Fifter the disease, or compliant shock, the art failure. List only or	e cause on each l	ine.			1 4	est,	Approximate Interval Between Onset and Death
	Physician		Immediate Pause (Final disease or condition resulting in death)	Contin		n wou	nd of	chest		
	/Medical Examiner		Tooling in data.	Due to (or as	a consequence of)					
		e.	Sequentially list conditions, I any, leading to immediate	Dirato (or as	a nonsequanda of):					
	d d ansit	Examiner	Sequentially list conditions, if any, leading to influentially cause. Enter Underlying Cause (Disease or injury that initiated events							
o,	te be executed ysician and e burial-transit		resulting in death) Last		a consequence of):					
3760,		lical								
K 68	certifica nding ph	Mec	IF FEMALE:	3c. If yes, outcome						
Вох	attend for us	Physician/Med	in the past 12 months?		2 Fetal death 3	Ectopic pregnancy Other (specify)	у		23d. Date Mont	of delivery th Day Year
P.O.	the de	iysic	1 □ Yes 2 □ No 9 □ Unknown	9☐ Unknown	t time of death 32	Cirior (specify)				
	The law requires that the death tte hes been signed by the atter bage 2 should be detached for u	by Pr	Part II. Other significant conditions con	tributing to death t	out not resulting in the u	nderlying cause giv	ven in Part I.	23e. Did tol	bacco use contrib	oute to the cause of death?
Records,	quires an sign uld be	ed b						1 🗆 Ye	es 2 No 3	3 ☐ Probably 4 ☐Unknown
000	aw re	piet						24a. Was a	24b. W	ere autopsy findings available ior to completion of cause of
Ä	The law ate hes l page 2 s	Completed						/ perfor	med? de	eath? ☑Yes 2☐No
Vital	Physician: The rthis certificate ral director, pag	Be (25. Was case referred to medical examiner?	(4-1).				ath (Check only on		
of	Phys this al di	2	1 X Yes 2 □ No □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □	ospital: 1 ☐ Inpati 28a. Date of Inji	ent 2 ER/Outpatier			Home 5 Reside	ence the	
uo	ling After fune	tion	1 □Natural 5 □ Pending 2 □ Accident investigation	(Month, Da		Wor	rk? Yes 2 X No	Subject	shot	himself
Division	Attending r death. ector: After by the fune	ifica	3 Suicide 6 ☐ Could not be	28e. Place of In	jury - At home, farm, str			28f. Location (Si		r or Rural Route Number,
Š	s after	Certification:	4 Homicide determined	building, e	tc. (Specify) Grave	yard		Cumber		mb Bedford Rd
	To the Hospitel or Attending I within 24 hours after death. To the Funeral Director: After & empletely filled in by the funer	cal			of my knowledge, death			e, and due to the c	ause(s) and man	ner as stated.
	tha H hin 24 the F nplete	Medical	one)	and manner si		29c. Licens				
	T with		29b. Signature and title of certifier	m. D		256. Licens				(Month, Day, Year) 15, 2004
,	N		20 Name and address of access with a		death (Item 23a) /Turn	Print)				10, 2007
6	11		30. Name and address of person who co		111 Penn	Street, I	Baltimor	e, Maryla	nd 21203	1
1	Sta	ate	31. Date filed (Month, Day, Year)	32. Regist	rar's Signatur	bach				
	Regist		NOV 1 9 2004	June	/~ /A	- Com				

_ roi								partment of Health and Mental Hygiene ertificate of Death Reg. N 2004 36819						
			Decedent's Name (First, Midd)	le, Last)						2. Date of D	eath		3. Time of Death	
	Physici /Medic		Nancy Vinc	ent O'Donne	11					Month Novemb	er 1		12:55 PM	
	Examin		4a. Facility Name (If not institution				4b. City, Tox	wn, or Locati	on of De	ath		County of Dea		
			9932 Kentsda					tomac				Montgomery		
	Funeral		5. Social Security Number	6. Sex 7. 1 ☐ M 21X F	Age (In yrs. last 70	<i>birthday)</i> Yrs.	If Under 1 Y Months D	ays Hou	der 24 H rs Mi		irth lay, Year)	9. Bi	rthplace (State or Foreign Country)	
	Director		182–28–0090 Usual Residence of Decedent		70					Dec 29	,193	3 Per	ınsylvania	
	yland how		10a. State 10b. County		10c. City, T	own or Lo	ocation			<u> </u>			10d. Inside City Limits	
	B Mar	ctor	Maryland Mont	gomery	Potor	nac						1 ☐ Yes 2√ No		
	or 28	Director	10e. Street and Number				10f. Zip Co				10g. Cit	izen of What C	Country?	
	ath w		9932 Kentsda					0854				ted St		
920	be filed within 72 hours after death with the Maryland tal Hygiene. id other then "neturel", or items 23a or 28a-f show event, the Medical Exart art must be notified at	by Funeral	11. Marital Status 1 Never Married 2 Mar 3 Widowed 4 Divorced	If Yes, Give	35.? ▼ No		13. Was Decedent of Hispanic Origin? (Specify Yes or No- if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 No Specify:					14. Race - Am Black, Wh Specify: W	ite, etc.	
9	72 ho netur	ted		nt's Education	1	6a. Dece	dent's Usual C	ecupation	nost of w	vorkina	16b. K	ind of Busines	s/Industry	
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21	filed w Hygier Sther th		17. Father's Name (First, Middle.	4		HC	memake	- T	- Al d - Al-			Home		
anc		o Be	Joseph Vince							_{ame (First, Middle} sa DeCai		Sumamej		
IZ	d 2 should be th and Mental 7 Is marked o traumatic eve	Ĕ	19a. Informant's Name/Relation:			19b. Mailii	ng Address (S			Rural Route Numi		or Town, State,	Zip Code)	
M			Mr. Kevin O'Don	nnell (So	n) 1	10117	Doneg	al Ct.	- I	Potomac,	MD.	20854		
Je,	of He	1	20a. Method of Disposition	• CD	com	e of Dispo	sition (Name of	of r place)	Nor	Date 7. 4,	20c. Lo	ocation - City o	r Town, State	
<u>E</u>	Pages nent of I		1 TBurial 2 □ Cremation 1 □ Donation 5 □ Other (\$		110	-	leaven		200		Sil	ver Sp	ring, MD.	
Baltimore, Maryland 21215-0036	permit. Page Department of Importent: If eny injury or once.		21. Signature of Funeral Service	22	2. Name and A $10~{ m E}_{ullet}$			eVol Fur Drive-Ga			, MD. 20877			
Е			23a. Patt1. Enter the disease, o shock, or heart failure. Lis	4					as cardi	ac or respiratory	arrest,		Approximate Interval Between Onset and Death	
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	sit od	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying		as a consequen	ice of):								
_	and I-trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or	as a consequen	ce of):								
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687	ficate physics the	edical		d										
Вох	eath certific attending p	M/m	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outco	me of pregnancy		Testania avast					23d. Date of de	alivery	
	the death certificate be executed y the attending physician and tched for use as the burtat-transit	Physiclan/Me	in the past 12 months? 1 ☐ Yes 2 🔀 No		t at time of death		⊒Ectopic pregr ☐ Other (specif					Month	Day Year	
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	To the Hospital within 24 hours a To the Funeral C completely filled it	TV Continue Bhusinian To the heat of an income						death occurred at the time, date and place, and due to the cause(for investigation, in my opinion, death occurred at the time, date ar						
	est of the control of										te signed (Mon	th, Day, Year)		
	20 1					D0033293 November 1, 2004								
	M		30. Name and address of person						11 -					
Frederick P. Smith, M.D. 5454 Wisconsin Ave. #1300 State 31. Date filed (Month, Day, Year) 32. Degistrar's Signature					suu, Chev	y Ch	ase, Mo	1. 20815						
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			For State Registra AMEND#17&18				artment of F		and Me		jiene leg. No.	2001	36820	
			Decedent's Name (First, Middle				-		2	. Date of Dea		Year	3. Time of Death	
	Physici /Medic		Violetta Pa	ntzinis						oct. 28		004	11:32 A M	
	Examin	er	4a. Facility Name (If not institution	*	ber)		4b. City, Town, o				4c. County of Death			
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R	Funeral Director		5. Social Security Number 579-70-8066	1 M 2 X F	'. Age (In yrs. last I 76	Yrs.	Months Days	Hours	Min.	Date of Birth (Month, Day)	, Year)	928 Gre	thplace (State or Foreign ountry)	
			Usual Residence of Decedent				1		U	une 1.) L	920 GI6	ece	
	arylan show	_	10a. State 10b. County		10c. City, To	own or Lo	ocation						10d. Inside City Limits	
	Ba-f	Directo	Maryland Montgo	nery	Si	<u>lver</u>	Spring					4146	1 Yes 2 No	
	a or		10e. Street and Number 8201 16th St	woot			10f. Zip Code	1.0			-	zen of What C	ountry?	
	ns 23	Funeral	11. Marital Status	12. Was Dece	dent Ever in U.S.	13.	Was Decedent of H If Yes, specify Cuba		gin? (Specif		J.S.A	4. Race - Ame	erican Indian,	
9	after or Itan	Fur	1 Never Married 2 XMarri		∑X No	ŀ			i, Puerto Ric	an, etc.)		Black, Whi	te, etc.	
933	iral',	d by	3 Widowed 4 Divorced	If Yes, Give Year or Da	les:		1 ☐ Yes 2X No	Specify:				Specify: wh	ite	
2	filed within 72 hours after death with the Maryland Hygiene. ythar than "natural", or Itams 23a or 28a-f show ant, the Medical Exambra must be multiful at	Completed	15. Decedent (Specify only highes		16	Give	dent's Usual Occup kind of work done DO NOT use retired	ation during most	t of working		16b. Kir	nd of Business	/Industry	
12	within iene. than	omp	Elementary/Secondary (0-12)	College (1-	4or 5+)		amstress	2)			C14	othing		
פ	0 = 5	Be C	17. Father's Name (First, Middle,	ast) Chris	Valiotis			18. Mothe	er's Name (F	irst, Middle, hana S				
<u>Ja</u>	should be filed within 72 hours after death with the Marylan Ind Mental Hygiene. Ind Mental Hygiene. Is marked other than "natural", or Items 23e or 28e-f show unatic event, the Medical Exercities in the Lear Milled at	To E	-Onoufrios Pa	ntzinis				Athen Chr	ristos	Valia S	tis	,		
Maryland 21215-0036	2 sho and Is mu		19a. Informant's Name/Relations	nip (Type, Print)	19	9b. Mailir	ng Address (Street	and Numbe	er or Rural R	Route Number	r, City or	Town, State,	Zip Code)	
	1 and Health	1	Maria Pantzini 20a. Method of Disposition	s/Daughter	20h Place	928	McGee Way	/ 01pe	y, MD			cation - City or	Town State	
20	Pages nent of h int: If its		1 XBurial 2 ☐ Cremation		tate cemei	tery, crei	matory`or other plac							
Baltimore,		ı	' 4 ☐ Donation 5 ☐ Other (S _i 21. Signature of Funeral Service I		Gate (eaven Name and Addre		1/2/2				ing, MD	
ñ	permit. Dep rtr Importe any inji		Van t. 3	elp									ng, MD 20904	
	7 7		23a. Page. Enter the disease, or shock, or heart failure. List	complications that ca	used the death. Do							- Spri	Approximate Interval Between	
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	/Medical Examiner		resulting in death)		r as a consequenc					_				
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9	ertifica ding pl	Physician/Medi	IF FEMALE:	020 Kuen eute									-	
Вох	eath certific attending p	lan/	23b. Was decedent pregnant in the past 12 months?	1 Live bir	ome of pregnancy th 2 Fetal dea nt at time of death		Ectopic pregnancy Other (specify)	1			2	3d. Date of de Month	livery Day Year	
o.	y the d	yslo	1 □ Yes 2X No 9 □ Unknown	9☐ Unkno		3.								
م'	The law requires that the de ite has been signed by the bage 2 should be detached	by Pr	Part II. Other significent condition	ns contributing to dea	ath but not resulting	g in the u	nderlying cause giv	en in Part I.		23e. Did to	bacco us	se contribute to	the cause of death?	
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ecords,	as as	Completed								24a. Was a		24b. Were at	utopsy findings available completion of cause of	
<u> </u>		Con								perfor	med? 2. ΔΝο	death? 1 ☐ Yes		
Vital R	ician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	Hospital:			37 04			Check only on				
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on	ding P th. : After I	tlon	1 Natural 5 Pending		, Day Year)	Injury	Wor	k? Yes 2 □1		50001100 11	, , , , ,	00001100		
Division of	l or Attandi after death. Diractor: A I in by the fu	ifica	3 Suicide 6 Could r	ned 286. Place	of Injury - At home, g, etc. (Specify)	farm, str	eet, factory, office		28f	Location (St		Number or Ri	ural Route Number,	
	tal or rs afte al Dir ed in	Certification;		Cultur	g, etc. (Opechy)				1	0.19 07 1007				
	To the Hospital or Attanding Physician: within 24 hours after death. To the Funaral Diractor: After this certific; completely illed in by the funaral director,	edical	(Check only 2 Medical	g Physicien: To the l Exeminer: On the ba	sis of examination a	lge, deatl and/ <i>o</i> r in	h occurred at the tin vestigation, in my o	ne, date an pini <i>o</i> n, deal	d place, and th occurred	due to the cat the time, d	ause(s) a ate and	and manner as place, and due	s stated. e to the cause(s)	
	thin 2 tha	Med	one) 29b. Signature and alle of certifier	and mann	er stated.		29c. Licens	e number		2	9d. Date	signed (Mont	h, Day, Year)	
			Shours !	5000 Dr.	2111	nr) DC19			1		9/2004		
	3)		30. Name and address of person	who completed cause	of death (Item 23a	a) (Type,								
	1/1		Shawn S. Clause	en MD 523	2 44th St	t. N	W Washing	ton,	DC 20	015				
	Sta		31. Date filed (Month, Day, Year)	32. Re	nistrar's Signature	B	Sparks							
	Registr	वा	NOY V4	4004		1	RYSURALS							

			1- State of Maryland / Department of Heal Certificate of De		ental Hygie Reg.		36821				
	Physici	an	1. Decedent's Name (First, Middle, Last)	1	2. Date of Death	Day Year	3. Time of Death				
	/Medic		Mary Elaine Price	1	November		6:35 AM				
	Examir	er	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Loc	cation of Death		4c. County of Dea					
	Funcion		Greater Baltimore Medical Center Towson 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If 1		Data of Birth	Baltime					
	Funeral Director			lours Min.	B. Date of Birth (Month, Day, Ye June 10,	1917	thplace (State or Foreign ountry) Canada				
	yland sow	ctor	10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits				
	within 72 hours after death with the Maryland ane. than "natural", or items 23a or 28a-f show te Madical Examinar must be notified at		MD Baltimore Monkton				1 ☐ Yes 2 No				
	or 28	Director	10e. Street and Number 10f. Zip Code		10g.	Citizen of What C	ountry?				
	s 23a		931 Maplehurst Lane 21111			USA					
	ter de iner	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Never Married 2 □ Married 12. Was Decedent of Hispar If Yes, specify Cuban, M	nic Origin? (Speci lexican, Puerto Ri	ify Yes or No- can, etc.)	14. Race - Am Black, Whi					
036	al', o	by		pecify:		Specify: V	Vhite				
21215-0036	72 ho	eted	15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during)	16b.	Kind of Business	/Industry				
2	han "	Completed	Elementary/Secondary (0-12) College (1-4or 5+) life. DO NOT use retired)	ig most of working							
2	be filed withir ital Hygiene. Id other then event, it e M.		3 Sales Clerk 17. Father's Name (First, Middle, Last)	Mothada Nama (Cinet Adiatella Ada La	Retail	Sales				
an	ld be ental ked o	To Be	777		First, Middle, Maid	en Sumame)					
Maryland	iit. Pages 1 and 2 should be artment of Health and Mental artant: If itam 27 is marked or njury or other traumatic ev	F	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and N	Emma Ge Number or Rural F		v or Town. State.	Zip Code)				
	ρ ‡ Γ = σ		E. Ervan Price / Son 931 Maplehu			cton, M					
ore	of He of He fitam		20a. Method of Disposition 1 🔀 Burial 2 🗆 Cremation 3 🔀 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place)	Dat		Location - City or					
Ë	Pag ment tant: I		`4 Donation 5 Specify) New Freedom Cemetery	Nov. 17	, 2004	New Free	dom, PA				
Baltimore,	permit. Pages 1 an Department of Heal Important: If itam 2 any njury or other once.		2). Signature of Filtreral Tevrice Licensee 22. Name and Address of	Facility J.J.	Hartenst	ein Mor	tuary, Inc.				
	40340		23a. Part Venter the disease, or complications that caused the death. Do not enter the mode of dying, sur	Street	New Fre	edom, I	PA 17349				
	Physician /Medical Examiner		flood, or heart failure. List only one cause on each line. Imprediate Cause (Final	ich as cardiac or r	espiratory arrest,		Approximate Interval Between Onset and Death				
			disease or condition resulting in death) Due to for as a consequence of:								
			h NO GAD Day in Compa	Due to (or as a consequence on).							
		ner	Sequentially list conditions,								
	acuted Ind transi	Examiner	that initiated events c.		,						
8760,	icate be executed physician and s the burial-transit	E	Due to (or as a consequence of):								
687	icate physi s the l	dical	d								
Box (The law requires that the death certific. Ite has been signed by the attending ploage 2 should be detached for use as t	Physician/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy			23d. Date of deli	of delices				
m	death e atte	icia	in the past 12 months? 1 Ves 2 Mills 4 Pregnant at time of death 5 Other (specify)	t at time of death 5 Other (specify)							
P. O.	that the died by the detached	hys	9 Unknown								
<u>'</u>	res tha iigned be del	o Be Completed by F	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in I	23e. Did tobacco	tobacco use contribute to the cause of death?						
oro	w requir been si should				1 Tes	Yes 2 No 3 Probably 4 Tunknown					
Records,	has t				24a. Was an autopsy	24b. Were au	topsy findings available ompletion of cause of				
			or West and the state of the st		performed? 1☐ Yes 2∰N	death?	2 No				
Vital	Attending Physician: r death. sctor: After this certific. by the funeral director.		Hospital:	Place of Death (C							
Division of	g Phys er this neral di	⊢ .	27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred								
joi	tending P Seath. tor: After i the funera	Certification:	1 XNatural 5 ☐ Pending (Month, Day Year) Injury Work? 2 ☐ Accident investigation M 1 ☐ Yes 2 ☐ No								
_	- 0 -	Tilii:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify)	28f.	Location (Street a City or Town, Sta	and Number or Ru.	ral Route Number,				
	spital of sours at naral D										
	To the Hospital of within 24 hours aff To the Funaral Discompletely filled in	edical	29a. Certifier (Check only one) 1 ☑ Certifying Physician: To the best of my knowledge, death occurred at the time, da 2 ☐ Medicat Examiner: On the basis of examination and/or investigation, in my opinion, and manner stated.	ite and place, and i, death occurred a	due to the cause(s at the time, date ar	s) and manner as nd place, and due	stated. to the cause(s)				
	To the Hos within 24 h To the Fur completely	Mec	29b. Signature and title of certifier 29c. License num			ate signed (Month					
	S.		6/ // / .		1	1/12-/2	771				
.1	14	-	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 126 011VER + 7516HTS, 0601NY551WHUS	3 []	/	1/14/11	4				
1			126 OLLIVER TETGHTS, GOINGS BUTLES	s, MC	21117						
	Stat Registra	e	31. Date filed (Month, Day, Year) 2004 32. Appliant Signature								
	riegistra	"	7012								

		1-	For Stete Registrar		State of M	larylar		artmer	nt of H					3 nni		368	22
Physi /Med		1.0		(First, Middle, Las E PALKO	st)							2. Date of De Month NOV •	aath Da	y 200 ⁴⁶	ar c	3. Time of 3 : 38	
Exam		4a.	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 15215 BARNESVILLE ROAD BOYDS							IV.	4c. County of Death MONTGOMERY						
Funera Directo		1	37-38- ual Residence of	6312 ¹	9x 7. A □ M 2 🗹 F	ge (In yrs. 57	last birthday) Yrs.	If Unde Months	Days	If Under 2 Hours	Min.	8. Date of Bir (Month, Da DEC 1		9.	Birthplac Country	NJ	or Foreign
Maryland I-f show	tor	_	. State MD	10b. County MONTGO	MERY		ty, Town or Lo								10d	l. Inside Ci	
h with the 23a or 28a	Funeral Director	10e. Street and Number 26105 FREDERICK ROAD						10f. Zip Code 10g					10g. Cit	izen of Wha	t Country	n	
5-0036 72 hours after death with the Maryland naturel; or iteme 23a or 28a-1 show alone Ear, institutel be notified at	þ		11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Armed Forces? 1 Yes, Give Year or Dates:			If Yes, specify Cuban, Mexican, Puerto Ricar						cify Yes or No Rican, etc.)	s or No- etc.) 14. Race - American Indian, Black, White, etc. Specify: WHITE				
21215-0036 ad within 72 hours aff giene. er than "naturei", or ure Me Jigal Eugral.	Completed	- 8	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) (Give kind of work done during most of working life. DO NOT use retired)								DOMESTIC						
Maryland 3 Id 2 should be filed Ith and Mental Hyg It is marked othe Traumatic event,	To Be C		17. Father's Name (First, Middle, Last) ROBERT CORSON 18. Mother's Name (First, Middle, Maide PATRICIA DWYER							ER							
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "naturel", or Iteme 23a or 28a-1 show any injury or other traumatic event, the Medical Eventimes the motified at		20a	CHRIST Method of Disp 1 Burial 2	osition	EGGI/DAU	20b. F		215] esition (Na	BARN me of other place	ESVI:	LLE Da	ate	BOY 20c. Le		ID or Town	2084 n, State	
Balti permit. Departm Importa any inju		21.	Signature of Fur	nogal Service Licen	eee /		H	ILLT	ON F	uner	AL E	IOME NESVI	LLE	. MD	20	838	
death certificate be executed Homeonic physician and extending physician and extending physician and extending points as the burial-transit	ı	Se if a cau	mediate Cause (f easiliting in death) quentially list con ny, leading to im use. Enter Under use (Disease or is it initiated events sulting in death) L	nditions, mediate tlying	b. Due to (or as d.	s a conseq	uence of):	Sms, b	l Ce	il Lu	ng.	Cancer				rinset and [beath konth
. Box 6 death certif e attending	by Physician/Med		FEMALE: b. Was decedent in the past 12 r 1 \(\text{Yes} \) 2 \(\text{S} \)	nonths?	23c. If yes, outcom 1 □ Live birth 4 □ Pregnant a 9 □ Unknown	2 🗆 Feta	Ideath 3	Ectopic p Other (s)						23d. Date of Month	delivery Da	ay h	rear .
Records, P.O The law requires that the that been signed by the age 2 should be detache	ted by Ph	Par	t II. Other signifi		compression		ulting in the u	nderlying (cause give	en in Part I.				se contribut			
The The page	Completed				·								osy rmed? 2 X No	24b. Were prior death	to compl	findings a letion of ca	available ause of
	atlon: To Be	2	Was case referrence examiner? 1 Yes 2 Amanner of Death 1 Accident	No					rsing Hom	ath (Check only one) Home 5 Residence 6 Other (Spe			fipecify)	HOUS			
in Pite	Certification:	3 Suicide 6 Could not be 4 Homicide determined						2	28f. Location (Street and Number or Rural Rol City or Town, State)				oute Num	ber,			
To the Hospital within 24 hours a To the Funeral it completely filled	Medical										as state	ed. e cause(s))				
To 1 To 1	Σ	291	o. Signature and t	Barrer					c. License	number	5			e signed (Me		y, Year)	34
15		30.		ss of person who	completed cause of MD 181	,		Print)						2083			× 1
S Regis	tate trar	31.	Date filed (Monti			rar's Signa				K							

			1 - For State Registrar	State of Marylar		artment of H			giene Reg. No. 2 (004	36823		
	Physici		1. Decedent's Name (First, Middle, Last) Louise Elizabeth	Duncell				2. Date of De Month Novembe	Day	Year 104	3. Time of Death 1:50 ^{a M}		
40.	/Medio Examin		4a. Fecility Name (If not institution, give s			4b. City, Town, or	Location of De		4c. County of Death				
			1051 Concord Ct. 5. Social Security Number 6. Sex	7. Age (In yrs.	last birthday)	Owing	If Under 24 H	Irs. 8. Date of Bin (Month, Da		lvert	lace (State or Foreign try)		
	Funeral Director		187-14-4696	M 2√x F 80	Yrs.	Months Days	Hours M	May 28	, 1924 , 1924	Penns	sylvania		
	/land		Usual Residence of Decedent 10a. State 10b. County	10c. Cit	ty, Town or Lo	cation				1	Od. Inside City Limits		
	Be-f eh	ctor	MD Calvert C	County O	wings						1 ☐ Yes 2 X No		
	with th	Funeral Director	10e. Street and Number 1051 Concord Court	t		10f. Zip Code 20736			10g. Citizen of U.S.		try?		
	death	nera		12. Was Decedent Ever in U Armed Forces?	J.S. 13. \		ispanic Origin?	(Specify Yes or No lerto Rican, etc.)		ce - Americ			
36	permit. Peges 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Itam 27 is marked other than "natural", or Itams 23a or 28e-f show samply injury or other traumatic event, I'm Madical Examinar must be nutified at ance.	by Fu	1 Never Married 2 Married 3 Widowed 4 XDivorced	1 ☐ Yes 2 No If Yes, Give Year or Dates:		I□Yes 2X No	Specify:			y: Whit			
21215-0036	72 hot	Completed	15. Decedent's Educ (Specify only highest grade	cation completed)	16a. Deced	dent's Usuai Occup. kind of work done o OO NOT use retired	ation during most of	working	16b. Kind of E	Business/Inc	dustry		
121	within tene. then	ompi	Elementary/Secondary (0-12)	College (1-4or 5+) 5+		otherapis			Self-l	Employ	ved.		
	be filed ital Hyg id other event,	Be	17. Father's Name (First, Middle, Last)				18. Mother's f	Name (First, Middle,					
Maryland	should to not Ment marked matic	Jo	Balint Wolf 19a. Informant's Name/Relationship (Type	oe, Print)	19b. Mailir	g Address (Street		se Balint Rural Route Numbe	er, City or Town	, State, Zip	Code)		
	end 2 saith ar n 27 is ier trau			Daughter)				gs, Maryl					
ore	Peges 1 or nent of He nent of He nent to the nettern to the netter		20a. Method of Disposition 1 Burial 2 Acremation 3 Removal from State 20b. Place of Disposition (Name of cametery, crematory or other place) 1 November 4, 20c. Location - City or Town, State										
Baltimore,	mit. Pe bartmer sortant r injury		Lee Crematory 2004 Clinton, Maryland 21. Signature of Funs to an action of Facility Lee Funeral Home Calvert, P.A.										
ă	Depa Impo any ii	113	Nichael W. I	861			ern Mar	yland Bly	d., Owi		MD 20736		
	Physician		23a. Pert 1. Enter the disease, or complic shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	cations that caused the deat e cause on each line. Bladde.	th. Do not ent	er the mode of dyin	g, such as card	liac or respiratory ar	rest,		Approximate Interval Between Onset and Death		
	/Medical Examiner			Due to (or as a conseq Ki Onew	quence of):								
	pe is	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying										
o,	rate be executed physician and the burial-transit	Examiner	Cause (Disease or injury that inflated events c. resulting in death) Last Due to (or as a consequence of):										
8760,	ate be physicie the bur	dicai											
Box 6	death certificat e attending phy ed for use as th	n/Me	IF FEMALE: 23b. Was decedent pregnant 23	3c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta		Ectopic pregnancy	3.50.0		23d. Da	ry			
P.O. B	0 0 0	by Physician/Med	in the past 12 months? 1 □ Yes 2 St to 9 □ Unknown	4 Pregnant at time of o		Other (specify)			M	onth	Day Year		
s, P.	uires that the signed by d be detacted	y Ph	Part II. Other significant conditions con	II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.									
ord	w require been sig should b								/es 2 □ No	3 Prob			
Vital Record	8 8 8	Completed						24a. Was autop perio	rmed3	prior to con death?	osy findings available inpletion of cause of		
Vital	Physician: The I this certificate har ral director, page	Be	25. Was case referred to medical examiner?	ospital:		Othe	20	Death (Check only o	ne)				
Division of \	Attending Ph r death. ector: After th by the funeral	Certification; To	27. Manner of Death	1 ☐ Inpatient 2 ☐ 28a. Date of Injury (Month, Day Year)	t 3□ DOA 28c. Injun Worl	4 Nursing		Residence 6 □Other (Specify) tribe how injury occurred					
			1 Matural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be	28e. Place of Injury - At h	M 1 []	Yes 2 □ No	28f. Location (Street and Number or Rural Route Number,						
Ο̈́		Certif	4 Homicide building, etc. (Specify) City or Town, State)										
	the Hospital or nin 24 hours atte the Funerel Dire	Medical	29a. Certifier 1 Certifying Phys (Check only one) 1 Medical Examin	sicien: To the best of my kno ner: On the basis of examina and manner stated.	owledge, death ation and/or inv	e occurred at the time restigation, in my op-	ne, date and pla pinion, death o	ace, and due to the occurred at the time,	cause(s) and m date and place,	anner as sta and due to	ated. the cause(s)		
	To the within 2 To the complet	Me	29b. Signature and title of certifier	OD A		29c. License			29d. Date signe				
			30. Name and address of person who col	moleted cause of death (Item	m 23a) (Type		5906	/		- 4-0	4		
_	6	20	Dr. Arati C. Padel	110 Hospita	1 Rol	Ste 21	2 Prin	ce Frederi	ck mb	206	78		
	Sta Registr		31. Date filed (Month, Day, Year) NOV 0 4	32. Registras Signa 2004 Marcus	ature &	Souls 5							

State of Maryland / Department of Health and Mental Hygien [] 36824 For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month 05° 2004 **Physician** Evelyn Redden 11:00 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 1171 Southview Drive Annapolis Anne Arundel 8. Date of Birth (Month, Day, Year) 9/13/1915 If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5 Social Security Number 7. Age (In vrs. last birthday) **Funeral** Months Min. Days Hours 1 □ M 2 KF Chester, MD 215-18-4382 89 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a State or 28a-f show ral', or items 23a or 28a-f shov Ever direct must be notified at 1 ☐ Yes 2 No Director MD **Arundel** Annapolis 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21401 1171 Southview Drive Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerlo Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: white 3 ¥Widowed 4 □ Divorced "natural', 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker; farmed Own home; farming 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Mental Mina E. Benton Gardner Elda Willard Gardner 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) item 27 970 Roundtop Drive; Annapolis, MD 21401 Patricia Redden Price /daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of H Importent: If ite any injury or ot once. 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) <u>Greensbor</u>o 11/10/2004 Greensboro, MD 21. Signature of Funeral Service License 22. Name and Address of Facility PO Box 160; Greensboro, MD 21639 Fleegle and Helfenbein Funeral Home, PA rumas 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a **Examiner** enll Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Hospitel or Attending Physicien: The law requires that the death certificate be executed use as the burial-tran Due to (or as a consequence of): رزازیال الکی الکی الکی الکی الکی Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performt 2 100 Be (25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 🗌 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Manger of Death 28c. Injury at Work? 1 Natura. 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No after death filled in by the 6 Could not be determined 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide To the Funerel 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medicai and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and the 9 28686 8 2 person who completed cause of death (Item 23a) (Type, Print) 32. Registrer's Signature 31. Date filed (Month, Day, Year) State Registrar 9 2004

			For State Registrar	State of Maryla		artment of I tificate of		R	eg. N2 0 0 4	36825
	Physicia	an	Decedent's Name (First, Middle, Last)	L				2. Date of Deat Month	Day 2004	3. Time of Death 9:40 a. M
	/Medic Examin	al	Dorothy J. Roug 4a. Facility Name (If not institution, give s Heartfields			4b. City, Town, Freder			4c. County of Dea	ith
	uneral irector		5. Social Security Number 210–18–5650 Usual Residence of Decedent	M 2 🔀 F 7. Age (In yi	rs. last birthday) Yrs.	If Under 1 Year Months Days		Ain (Month Day	9. Bir 24, 1927	thplace (State or Foreign ountry) Pennsylvani
o Ifter death with the Maryland	plene. r then "natural", or items 23e or 28a-f show the Medical Exert it art must be notified at	Funeral Direc	10a. State 10b. County Maryland Frederic 10e. Street and Number 1820 Latham Drive	k 12. Was Decedent Ever in Armed Forces? 1 □ Yes 2 愛 No		10f. Zip Code 2170 Was Decedent of f Yes, specify Cul	Hispanic Origin ban, Mexican, P	? (Specify Yes or No- uerto Rican, etc.)	Og. Citizen of What Co U.S.A. 14. Race - Am. Black, Whi	encan Indian,
C L L I 3-0030 filed within 72 hours after	ital Hygiene. Id other then "natural", c event, the Medical Exar	Completed by	3 Widowed 4 □ Divorced 15. Decedent's Edur (Specify only highest grade) Elementary/Secondary (0-12) 12 17. Father's Name (First, Middle, Last)	If Yes, Give Year or Dates: cation a completed) College (1-4or 5+)	16a. Dece (Give life.	dent's Usual Occu kind of work done DO NOT use retire	ipation e during most of ed)	working Name (First, Middle, I	Specify: 16b. Kind of Business Own home Maiden Sumame)	/Industry
Iryland should be fil	nd Menta marked imatic ev	To Be	Charles Brock 19a. Informant's Name/Relationship (Ty	pe, Print)	19b. Maili	ng Address (Stree		ed Frank r Rural Route Number	; City or Town, State,	Zip Code)
	Department of Health ar fmportant: if item 27 is any injury or other treuonce.		Ronald Rough - Son 20a. Method of Disposition 1 Burial 2 Cremation 3 R 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Access	emoval from State	Place of Dispo cemetery, crea Lade Cer	sition (Name of matory or other planetery netery 2. Name and Addi	ace) 1	L-4-2004 Stauffer Fu	20c. Location - City or Walkersvil	lle, Marylan
/1	ysician and special and special transit specia	dical Examiner	23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a cons	equence of): TRACK requence of): The Se	eumon Tuk	ia lection	closof Vas		Approximate Approximate Interval Between Onset and Death OAYS 7 DAYS
death	ied by the attending phi detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 1 No 9 ☐ Unknown	3c. If yes, outcome of pre 1 □ Live birth 2 □ F 4 □ Pregnant at time of	etal death 3[□Ectopic pregnan □ Other (specify)	су		23d. Date of de Month	blivery Day Year
rdS, P.	been signed by should be deta	þ	Part II. Other significant conditions con	ntributing to death but not	resulting in the u	nderlying cause g	oven in Part I.		bacco use contribute t es 2□No 3□P	to the cause of death? Probably 4 ZUnknown
I Records, P.O The law requires that the	S C1	Completed	TAILURE to TI	hrive				24a. Was a autops perform	sy prior to	
n of Vital	within 24 hours after death. To the Funeral Director: After this certificate hi completely filled in by the funeral director, page	Certification: To Be C	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	28a. Date of Injury (Month, Day Year		f 28c. Inj M 1	other: 4 ☐ Nursi ury at ork? ☐ Yes 2 ☐ No	Death (Check only or ng Home 5 Residence 28d. Describe he	10)	Living
DIVI To the Hospital or At	within 24 hours after death. To the Funeral Director: A completely filled in by the fu	edical Certifi	4 Homicide determined 29a. Certifier (Check only one) Check only one) determined determined	28e. Place of Injury - A building, etc. (Sp. sician: To the best of my ner: On the basis of examand manner stated.	ecify) knowledge, dea	h occurred at the	time, date and p	olace, and due to the coccurred at the time, of	n, State) ause(s) and manner a late and place, and du	is stated. le to the cause(s)
Tott	withi To tl	W	29b. Signature and itte of certifier	eilly M			nse number		11 3 Z	
	6		30. Name and address of person who con the state of the s	ompleted cause of death (Item 23a) (Type	Wise A	he d-	1, Freber	rick, me	2004 21701
	St: Regist	ate	NOV 0 F 20		~ 4	1	1			

DHMH 17 Rev 1/2001

		1	For State Registrar	State	of Maryla	and / Depa <i>Ce</i> a	artmer <i>rtifica</i> :	nt of H	ealth a Death	and M	lental Hy	giene Reg. No.	200	4	368	26
200	ysicia		1. Decedent's Name (First, Middle	, Last)							2. Date of De	ath Day	· Y	'ear	3. Time of	
	ysicia ledic		Miriam W	. Ro	hrer						Novembe		200		9:00	AM
Exa	amine	er	4a. Facility Name (If not institution		number)				Location of	of Death		4c.	County of	Death		
		4	7044 Rock Cree		7 4 (1	na da na hiindanda d		rede	rick If Under:	24 Hrs	0.0-14.0		eder:			
Fund Direc			5. Social Security Number	6. Sex 1 ☐ M 2 ဩ F		rs. last birthday) Yrs.	Months	Days	Hours	Min.	8. Date of Bir (Month, Da March	av. Year)	929	Coun	lace (State of try)	' Foreign
	J.LOI	-	212-24-6649 Usual Residence of Decedent		13						march.	14,	949	mar	yland	
yland	=		10a. State 10b. County		10c.	City, Town or Lo	ocation							1	0d. Inside Cit	y Limits
Ma e-f	il in	cto	Maryland Frede	rick		Frederi	ck								1 🗌 Yes	2 X No
iff th	S DS	Directo	10e. Street and Number				10f. Zi	Code				10g. Citi	zen of Wha	at Coun	try?	
ours after death with the Marylan utry, or Items 23a or 28e-f show	1	rai	7044 Rock Cre					2170					ited			
er de Items	Sec.	Funerai	 Marital Status Never Married 2 Marr 	Armed	ecedent Ever in Forces? as 2 🔯 No	I U.S. 13.	Was Dece If Yes, spe	dent of Hi cify Cuba	spanic Orig n, Mexican	gin? (Spe 1, Puerto	ecify Yes or No Rican, etc.))-	14. Race - Black,	Americ White,		
rs aft	E E	by F	3 ☐ Widowed 4 ☐ Divorced	If Yes.			1 ☐ Yes	2 X No	Specify:				Specify:	Whi	te	
72 hours after death w natural, or Items 23a	3		15. Deceden	's Education		16a. Dece	dent's Usu	al Occupa	ition			16b. Ki	nd of Busir	ness/Inc	lustry	
thin 7	Page	pie	(Specify only highes Elementary/Secondary (0-12)	Ť ·	e (1-4or 5+)	life.	DO NOT L	ise retired,	luring most)	t of work	ng					
A wigien	3	Completed	12			Hom	emake	r					Own I	Home		
Lat y lated within 72 hours after death with the Maryland and Mental Hygiene.	0 V 0 L	Be	17. Father's Name (First, Middle,								(First, Middle		Surname)			
should Men	natic	ပ္	Charles M. Wh			105 14-18		(0)			y Crame		T 0:		2 11	
d2st d2st than 7 is r	traur		19a. Informant's Name/Relations								Il Route Numb					
s 1 and 20 item 27 item 27	or other traumatic event, the Madical	4	Ralph C. Rohre 20a. Method of Disposition	ı / nusb		. Place of Dispo	sition (Na	me of			Freder		Mar cation - Cit			12
Pages nent of B	y or		1 Burial 2 □ Cremation 4 □ Donation 5 □ Other (S)			cemetery, crei Lon Luth	-		1 1	Nove	nber 4 2004	Midd	loton	m ī	Maryla	nd
permit. Pages Department of Important: If it	in ei		21. Signature of Funeral Service		1					y Sta	uffer I					iid
	any ir	А	Hung /		V						ke Fre					1702
			23a. Pari 1. Enter me diserse, or spock, or mart failure. List	on vone carrie of	at caused the	Do not ent	ter the mo	de of dying	, such as	cardiac o	or respiratory a	rrest,			Approximate Interval Betw	veen
Physic	ian		Immediate Cause (Final disease or condition		11										Onset and D	
/Medi Exami			resulting in death)	Due Due	to (or as a cons	sequence of):	•				-	/				
LAGIIII	-	Ļ	Sequentially list conditions,		to (or as a cons		1016	= 60	5-	>						
pet	usit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Unique y	\$ Due	to (or as a cons	equence on.										
be executed ician and	al-tra	Exar	that initiated events resulting in death) Last	c	to (or as a cons	sequence of):								+		
cate be executed ohysician and	the bur	cail		d												
tifical ug phy	as th	ledi		1												
ath cer	esn J	an/N	23b. Was decedent pregnant		outcome of pred		∃Ectopic p	regnancy				2	3d. Date o		*	
e dea the at	ped fo	hysician/Medicai	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		egnant at time o iknown	of death 5	Other (s	pecify)					Month		Day Y	ear
that the death certific ed by the attending pi	detacl	۵,	Part II. Other significant condition	nas contributing to	n death hut not i	resulting in the u	nderlying	rause dive	n in Part I		23a. Did t	ohacco u	se contribu	ite to th	e cause of de	aath?
The law requires that the death certificate at the been signed by the attending phys	eq p	d by	Denhe			, , , , , , , , , , , , , , , , , , ,		Jacob g c			12				ably 4 ⊡Ua	
v requ	shoul	eted									24a. Was	an	24h Wei	re autor	sy findings a	vailable
an: The law	19e 2	Comple									autor perfo	psy prmed?	prio dea	r to con th?	rpletion of ca	use of
	ŏ	Ö	25. Was case referred to medical						26 Place	of Death	1 Yes	2₽No	1 1 4	Yes	2 No	
ysic ysic	dire	OB	examiner? 1 Yes 2 No	Hospital: 1	☐ Inpatient 2	☐ ER/Outpatier	nt 3 D	OA Othe	arr.		ne 5 Resi		☐Other ((Specify)	1,775
ding Phy After this	neral	n: T	27. Manner of Death 1 ☑ Natural 5 ☐ Pendin	28a. Da	ate of Injury fonth, Day Year,	28b. Time o	f	28c. Injury Work	at		28d. Describe	how injur	occurred			
andir or: Al	he fu	Satic	2 ☐ Accident investig	gation			М		′es 2 □ ì	No						
l or Attandi after death. Diractor: A	n by t	Certification:	3 Suicide 6 Could in determined	ined 286. Pl	ace of Injury - A ilding, etc. (Spe	t home, farm, str ecify)	reet, factor	y, office			28f. Location (: City or To		i Number (or Rural	Route Numb	er,
pital pital and and and and and and and and and and	99		29a, Certifier Certifyin	a Dhuaisina. Ta	the best of much	an accident and a state of	<u> </u>									
Hos 24 ho	etely i	Medicai	(Check only 2 Medicel one)	g Physician: To Exeminer: On th and m	e basis of exam	ination and/or in	vestigation	n, in my op	e, date and inion, deat	th occurr	ed at the time,	date and	and manne place, and	er as sta	the cause(s)	
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this ce wife	completely filled in by the funeral	Me	29b. Signature and title of certifie				29	c. License	number			29d. Date	signed (A	Aonth, L	Day, Year)	
. , ,				Col	500			DI	763	2		110	0	2	200	4
L.	2		30. Name and address of person	who completed c	ause of death (I		Print)	2, -						-		
0	1			4569			1	' 5	C /	F	-dr-a	- 5	me	2	2179	2/
- Re	Stat gistra		31. Date filed (Month, Day, Year)	0 5 2004	2. Registrat's Sig	gnature	9	Spi	aka	1.						

		1	For State Registrar	State	of Marylar	nd / Depa <i>Cei</i>	artmen rtificat	t of F e of .	lealth ar <i>Death</i>	nd Me	ntal Hy	giene Reg. No.	2004	36827
			1. Decedent's Name (First, Middle	e, Last)						2	. Date of De. Month	ath Day	Year	3. Time of Death
Phy:	sicia edica		Patricia L	ee Reaso	ner					1	Novemb			14:10 M
	mine	_	4a. Facility Name (If not institutio 4116 7th Str		umber)				r Location of t Beach	Death		4c.	County of Deat	vert
			5. Social Security Number	6. Sex	7. Age (In yrs.	last birthdav)	If Under			4 Hrs. 8	. Date of Birt	th		
Fune Direct			263-86-6919	1 □ M 2 🔀 F	55		Months	Days	Hours	Min.	(Month, Da	y, Year)	949 Ir	nplace (State or Foreign untry) udiana
			Usual Residence of Decedent								P	-c , -c		
nylan how	1		10a. State 10b. County		1	ity, Town or Lo								10d. Inside City Limits
Ba-f		cto		lvert		North I								1 X Yes 2 □ No
vith th		Director	10e. Street and Number				10f. Zip					10g. Citi	zen of What Co	untry?
s 232		Funeral	4116 7th Str		cedent Ever in U	10 12 1	Mac Door	207	1.4 Iispanic Origin	n2 /Space	fu Voc or No		USA 14. Race - Ame	ican Indian
ter de		Š	 Marital Status Never Married 2 ☐ Mar 	Armed			f Yes, spec	offy Cuba	an, Mexican, F	Puerto Ri	can, etc.)		Black, White	
urs al		۾	3 ☐ Widowed 4 🏋 Divorced	If Yes. C	Sive		1 🗌 Yes	2 13 No	Specify:				Specify: Wh	ite
72 ho		Completed		nt's Education st grade completed	0	16a. Deced	deni's Usua	al Occup	ation during most o	of working		16b. Kii	nd of Business/l	ndustry
thin i		nple Ple	Elementary/Secondary (0-12)		(1-4or 5+)	life. I	DO NOT us	se retired	d)	, working		Cal	f Timela	arrod
be filed within 72 hours atter death with the Maryland tall Hygiene. The coher than "nature!", or Items 23a or 28s-1 show event if the Maryland are successful to the control of the cont	1		47 5 dt - 4 N (5 - 4 Middle	4		4	onsul	tant		- No (I	Cina Middle		f Emplo	
D maintain		Be	17. Father's Name (First, Middle,	Last)							First, Middle,			
n y le		၉	John Rober 19a. Informant's Name/Relations		ng	19h Mailir	na Address	(Street			Ruth		nis r Town, State, Z	in Code)
Man 12 s lith an 127 le lith an 177			Robert Z. Rea		m)				Summit					VA 23832
S 1 ar Heal Heal			20a. Method of Disposition	SOIICI (SC	20b.	Place of Dispo	sition (Nan	ne of			år 5,		cation - City or	
Page entol			1 ☐ Burial 2 TCremation 4 ☐ Donation 5 ☐ Other (5		n State _	ee Cre			1	2004	- 1	Cli	nton, M	D
perilliniore, Index yiellion 2.12.13-0030 permit. Pages 1 and 2 should be filed within 72 hours atter death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturel; or Items 23s or 28s-1 ehow any injury or other trainmits event.	g		21. Signature of Funeral Service						ss of Facility			al Ho	me Calv	vert, PA
	Suce		Carrier C	off					ern Ma				Owings,	
- 19 mg			23a. Part1, Enter the disease, o shock, or heart failure. Lis	r complications lhat only one cause or	caused the dea each line.	th. Do not ent	er the moo	e of dyin	ng, such as ca	ardiac or r	espiratory ar	rrest,		Approximate Interval Between
Physici	an		Immediale Cause (Final disease or condition	· Ac	aten	nyoca	on di	013	Fufar	ctro				Onset and Death
/Medio			resulting in death)	Due t	o (or as a consec		,	-	,		1			
LAGITIII		_	Sequentially list conditions, if any, leading to immediate	b. Due t	o (or as a consec	Sclen	tic	VC	socul.	ar	dise	æ,		
per tisc		nine	rany, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	<	-			T-\1						
execu axecu al-tra		Examiner	that initiated events resulting in death) Last		o (or as a consec			1						
licate be executed physician and sthe burial-transit		dical		d										
titicat g phy		0												
ath cer attendir		an/N	IF FEMALE: 23b. Was decedent pregnant		utcome of pregn		Ectopic pr	eαnancy	,			2	3d. Date of deli	
b dea he att		Physician/M	in the past 12 months? 1 Yes 2 No 9 Worknown		gnant at time of o		Other (sp						Month	Day Year
The law requires that the death certitions that has been signed by the attending same 2 should be detached by use as		Phy	Part II. Other significant conditi	ans contribution to	death but not re-	culting in the u	adarhiia a a	21100 711	on in Bort I		23e Did to	obacco u	eo contributo to	the cause of death?
w requires that if been signed by should be detected.	3	ò	Part II. Other arginiteant conduc	ons contributing to	deall but not re-	saiting in the di	ide lyling c	ause giv	on mraiti.					bably 4 Tunknown
w requires to been signed be		Completed									040 1450		245 14/	fodina avallable
ne lav	2	m									24a. Was autop perfor			opsy findings available ompletion of cause of
VICAL ICIAN: TI Sertificate Actor pa		ပိ	25. Was case referred to medica	1					26 Place of	d Dooth //	1 Yes	2∐ No	1 🗆 Yes	2 No
Physiclan: r this certificater and director		0 0	examiner? 1 Yes 2 No	Hospital	Inpatient 2]ER/Outpatien	t 3 DC	Oth	00		5 PResid		☐Other (Spec	ihr)
g Phy g Phy earthis		L :	27. Manner of Death		e of Injury onth, Day Year)	28b. Time of Injury		8c. Injur Wor			d. Describe h			
MISION OF VII. The law and death. The death. Attention of the continue of the control of the c		atlo	20,100,0011	igation		,,	М		Yes 2 □No	>				
or Atte		Certification:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	nined 286. Pla	ce of Injury - At h ding, etc. (Speci		eet, factory	, office		281	Location (S City or Ton			al Route Number,
urs af			100											
the Hospital or hin 24 hours atte the Funerel Dir		edical	29a. Certifier 1 Certifyi (Check only 2 Medical	ng Physician: To the Examiner: On the	he best of my kni basis of examina anner stated.	owledge, death ation and/or inv	occurred vestigation	at the tir , in my o	ne, date and p pinion, death	occurred	due to the d at the time, d	cause(s) date and	and manner as place, and due	stated. to the cause(s)
To the Hospital or Attendi within 24 hours after death. I to the Funerel Director: A completely filled in by the H		Me	29b. Signature and tille of certific	-			290	. Licens	e number			29d. Date	signed (Month	Day, Year)
F > F (Hour	1/11	2		1	11	72.5	4		11	14/0	1_
			30. Name and address of person						() !			" "	1 10.	
10			Raymon A. No		32 Cox		Hunti	ngto	wn, MD	206	39			
Per	Stat	_	31. Date filed (Month, Day, Year	0 5 2004	Registra s Sign		Som	the s	,					-

DHMH 17 Rev 1/2001

		ľ	For State Registrar	State of Man	yland / Depa <i>Ce</i> l	artment of H rtificate of L	ealth and M Death	ental Hygie Reg.	n2004	36828
			1. Decedent's Name (First, Middle, Last)				2. Date of Death		3. Time of Death
	Physici		Charlotte Naom	Doland				November	3, 2004 Year	6:15 p M
	/Medio Examir		4a. Facility Name (If not institution, give			4b. City, Town, or	Location of Death	1	4c. County of Dea	
	Lxamii						Largo		Prince (
	Funeral		Manor Care 5. Social Security Number 6. Se	x 7. Age (/	n yrs. last birthday)	If Under 1 Year		8. Date of Birth		thplace (State or Foreign
	Director		578-22-6720	□M 21 X F	85 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, Ye March 17	1919 C	MD
			Usual Residence of Decedent					Haren 17	1319	TID
	yland 30W		10a. State 10b, County	10	Oc. City, Town or Lo	cation				10d. Inside City Limits
	Mar Fed	ţ	MD Prince Ge	eorae's		Upper Mar	1boro			1 TYYes 2 □ No
	1 the	Director	10e. Street and Number			10f. Zip Code		10g.	Citizen of What Co	ountry?
	3a o		3811 Largo Road			2	20772		USA	
	72 hours after death with the Maryland naturel', or liems 23a or 28e-1 show liteal Examiner must be notified at	Funeral	3811 Largo Road 11. Marital Status	12. Was Decedent Eve	er in U.S. 13.		spanic Origin? (Spe	cify Yes or No-	14. Race - Ame	
"	after dea or items	F	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 🛣 No		f Yes, specify Cubai	n, Mexican, Puerto F	Rican, etc.)	Black, Whit	e, etc.
036	urs a	ρ	3 XWidowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2X No	Specify:		Specify:	White
5-0036	n 72 hours naturel',	Completed	15. Decedent's Edu	cation	16a. Dece	dent's Usual Occupa	ition Juring most of working	166	b. Kind of Business	
7	S - 3	ple	(Specify only highest grad Elementary/Secondary (0-12)	College (1-4or 5+)	(Give	kind of work done d DO NOT use retired;	luring most of workin)	ng		
2121	filed within Hygiene. ther then int, the We	E	12	College (1-401 5+)		Supervi	.sor		Telephone	Company
		Be C	17. Father's Name (First, Middle, Last)			-	18. Mother's Name			- Company
a	D P 3 7	0 18	Thomas Perry				Magg	ie Botel	er	
Maryland	d 2 shou th and M 7 is mar treumati	-	19a. Informant's Name/Relationship (T)	rpe, Print)	19b. Mailir	ng Address (Street a	nd Number or Rural			Zip Code)
Ž	and 2 ealth a n 27 is		Rhonda Callahan/Fi	ciend	3903	Largo Roa	d, Upper	Marlboro	MD 2077	2
ē,	- I 0 =	1 3	20a. Method of Disposition		20b. Place of Dispo	sition (Name of	Da		. Location - City or	
2	0 = 2		1 ☑ Burial 2 ☐ Cremation 3 ☐ F ' 4 ☐ Donation 5 ☐ Other (Specify)			natory or other place		/2004 G		
Baltimore,			21. Signature of Funeral Service Lisens			.1 Cemeter . Name and Addres			uitland,	
Ba	permit. Departr Importe any infl		De Carlotte	101), Dunkirk			Home, P.A.
			23a. Part1. Enter the disease, or compl	ications that caused the					110 Z0734	Approximate
			shock, or heart failure. List only o	ne cause on each line.				1		Interval Between Onset and Death
	Physician	1	Immediate Cause (Final disease or condition resulting in death)	Houte ce	velval '	vascula	v accid	ent		2 mouth
	/Medical Examiner		Toolaining in doctory	Due to (or as a c	onsequence of):					- 0
		L	Sequentially list conditions,	. Typevi	rencion			21		7 Loyeaus
	ed sit	ine	cause. Enter Underlying Cause (Disease or injury	Oue up (or as a c	onsequence of):	000-	Pailine			>100 W
	ecut and -tran	Examine	that initiated events resulting in death) Last	Due to (or as a c	srive v	lear t	Julione			>10 years
60,	cian cian curia	E		Chulou	- ara	al Fil	Pailure hilleri	on		4 CVPDIR
68760,	icate be executed physician and s the burial-transit	edical		d. Charles	2 30.70		7. 200			1) flats
			IF FEMALE:	220 If you system out					T	-
Box	attend for us	lan/	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of p 1 ☐ Live birth 2	Fetal death 3	Ectopic pregnancy			23d. Date of del Month	ivery Day Year
0	the a	Physician/M	1 ☐ Yes No 9 ☐ Unknown	4 Pregnant at tim 9 Unknown	e of death 5	Other (specify)			, was the	July 7 du
Θ.	law requires that the deeth certi as been signed by the attending 2 should be detached for use a	Ph	Part II. Other significant conditions con	etaibutine to do ath but a			-1-0-41	non Biddeles		the cause of death?
ŝ	ires ti signe d be c	by	11 . 1 .	400	ot resulting in the u	iderlying cause give	nın Panı.			
orc	w requir been si should	ted	Hyperlipiden					1 10 105	200 NO 3 P	obably 4 Unknown
of Vital Records,	e law re has be	Completed						24a. Was an autopsy	24b. Were au	topsy findings available completion of cause of
<u>~</u>	Th ate	Con						performed	2 death?	
ita	Physicien: Th this certificate ral director, pag	Be (25. Was case referred to medical examiner?				26. Place of Death			
1	ysicie	0	1 ☐ Yes 2 No	lospital: 1 Inpatient	2 ER/Outpatien	t 3□ DOA Othe	r: 4 Nursing Hom	e 5 Residence	6 □Other (Spec	cify)
		ü	27. Manner of Death 1 SNatural 5 ☐ Pending	28a. Date of Injury (Month, Day Ye	28b. Time of Injury	28c. Injury Work	at 21	8d. Describe how in	njury occurred	
. <u>Ö</u>	Attending ir death. ector: After by the fune	atle	2 Accident investigation				es 2□No			
Division	or Atten after deat Director: in by the	tific	3 Suicide 5 Could not be determined	28e. Place of Injury building, etc. (3	- At home, farm, str	eet, factory, office	2	8f. Location (Street City or Town, St	and Number or Ru	ıral Route Number,
Q	tel or after safter el Dire ed in b	Certification;		3,,	,,			,	,	
	To the Hospitel or Ai within 24 hours after of To the Funerel Direc completely filled in by	dical	29a. Certifier Certifying Physics (Check only 2 Medical Exami	sician: To the best of m	ny knowledge, death	occurred at the time	e, date and place, ar	nd due to the cause	e(s) and manner as	stated.
	ths H lin 24 the F splete	0	one)	and manner stated	i.		mon, death occurre	u at the time, date	and place, and due	to the cause(s)
	To the To the complet	Σ	29b. Signature and title of certifier	a		29c. License		29d.	Date signed (Montl	h, Pay, Year)
.,.			Mein 6. (Kle	emple	e vy	104	2049	[No	vender 4	, 2009
	. 0		30. Name and address of person who co			Print)	11	ta . 3	9	777
	12		Alain. G. Champ		F	pper Ma	anl bovo	ma	. 20	14
	Sta		31. Date filed (Month, Day, Year)	32. Registrats	Signature	1				
	Registr	ar	NOV U	± ZWU4 P DU	ALLE S.	Aprile				

		For State Registrar	State of	Maryland	/ Depa	artment rtificate	of H	ealth a Death			Reg. No	20	04	36829
Physici /Medic		1. Decedent's Name (First, Middle The Im G I	. Schus			45 City T		Logation of		2. Date of D Month (O	/ Da) [Year of Death	3. Time of Death 11:38a ^M
Examin	er	4a. Facility Name (If not institution						Location of						
Funeral		Sprinbrook Adv 5. Social Security Number	e Sov	7. Age (In yrs. la		If Under 1	Year	Sprin		8. Date of B	irth	UIL	9. Birthp Cour	lace (State or Foreign
Director		217 09 9516	1□ M 2□ F	84	Yrs.	Months	Days	Hours		May 1		20		yland
pur *		Usual Residence of Decedent 10a. State 10b. County		10c. City,	Town or Lo	ocation							1	0d. Inside City Limits
Maryli f sho	ō		gomery	Silv	er Sp	ring								1 ☐ Yes 2 No
r 28a	Directo	10e. Street and Number	3		-	10f. Zip (Code				10g. Cit	izen of	What Cour	ntry?
th with	alD	12325 New Hamps	shire Avenu	ıe		2	0904	.					USA	
tame	Funeral	11. Marital Status	12. Was Deced Armed For	dent Ever in U.S.	. 13.	Was Decede If Yes, speci	ent of Hi fy Cuba	ispanic Orig n, Mexican,	gin? (Spec , Puerto R	city Yes or Nican, etc.)	lo-		e - Americ ck, White,	can Indian, etc.
rs afte	by F	1 Never Married 2 Married	If Yas Give	•		1 ☐ Yes 2	X No	Specify:				Specif	v: Wh	ite
be filed within 72 hours after death with the Maryland tal Hyglene. ad other than "natural", or Itame 23s or 28s-f show event, the Madical Examinar must be notified at			t's Education		16a. Dece	dent's Usual	Occupa	ation	t of working	a	1		usiness/in	,
thin 7 e. en "n	Completed	Elementary/Secondary (0-12)	st grade completed) College (1-	4or 5+)	life.	kind of work DO NOT use Cler)	OF WORKING	9			worth	s Store
led w lygien her th		17. Father's Name (First, Middle,	(act)			CTEL	K.	18 Mother	r's Name	(First, Middl				Store
2 should be filed within and Mental Hygiene. Is marked other than sumatic event, I'm Me	Be	100	LASI)							Barra		Delivati		
should not Me mark	To	Joseph Hose 19a. Informant's Name/Relations	hip (Type, Print)		19b. Maili	ng Address	(Street a					or Town,	State, Zip	Code)
alth alth altra		Patricia Willi	iams / Daug	ghter	7514	Sweet	Ηοι	ırs Wa	ay Co	lumbia	a, Ma	ry1	and	21046
of He		20a. Method of Disposition	3 Demoval from 9	Cer	nce of Dispo	osition (Nam matory or ott	e of her place	e)	Da	ate	20c. L	ocation -	City or To	own, State
permit. Pages 1 and 2 should be Department of Health and Mental Important: If Item 27 is marked any injury or other traumatic events.		'4 □Donation 5 □ Other (S	(pecify)		e of I	leaven	Сел	netery	y 11/	2/200	4 Sil	ver	Spri	ng, Maryla
permit. Pages 1 Department of He mportant: If Iten iny injury or oth		21. Signature of Funeral Service	Licensee			2. Name and								
402 a d		23a Part1. Enter the disease, or	complications that ca	used the death								er S	pring	Approximate
Physician /Medical		shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)	a. /	cluance		enile	, D)eme	en tr	cy.			/	Interval Between Onset and Death
Examiner		Due to (or as a consequence of):												
	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (c	or as a conseque	ence of):									
certificate be executed adding physician and use as the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	C	or as a conseque	ance of):									
be ex ician burial	cal E	roganing in activity and	0) 01 900	or as a conseque	ence or).									
icate physics the	_		d											
leath certificat attending phy I for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant		come of pregnan		Tratania au						23d. Da	te of delive	ery
0 0 0	sicia	in the past 12 menths? 1 □ Yes 2 ☑ No		nth 2 □ Fetal of ant at time of dea		□Ectopic pre □ Other (spe						Ma	onth	Day Year
requires that the de- een signed by the a hould be detached f	Phy	9 Unknown			ala - la ab			en in Don't		220 Did	tobassa	100 000	tributa to ti	he cause of death?
Se Ded	þ	Part II. Other significant conditi	ons contributing to de	ath but not resul	ting in the t	indenying ca	iuse give	en in Pari I.	•		Yes 2		3 ☐ Prob	
v requir been si should	Completed									24a. Wa			Were auto	ppsy findings available
e lav has	mpi									aut	opsy formed?	-	prior to co death?	impletion of cause of
ician: Th certificate rector, pag	C	25. Was case referred to medica	1					26 Place	of Death	1 ☐ Yes (Check only			1 🗆 Yes	2 No
	0 8	examiner? 1 Yes 2 No	Hospital:	npatient 2 E	R/Outpatie	nt 3 DO	A Othe	ar /		ie 5 Res		6 Oth	ner (Specif	'v)
iding Phys th. After this funeral di	n: T	27. Manner of Death	28a. Date o		28b. Time o		Bc. Injun			8d. Describe				
r Attending Fer death.	atic	2 Accident invest	gation			М		Yes 2□N						
or Attend fler death director: in by the	ertification;	3 Suicide 6 Could 4 Homicide determ	nined 286. Place	of Injury - At honing, etc. (Specify)	ne, farm, st	reet, factory,	, office		2		(Street all own, State		per or Rura	al Route Number,
To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	C	29a. Certifier 1 Certifyi	ng Physician: To the	best of my know	riedos des	th occurred s	at the tim	ne, date and	d place a	nd due to th	e cause/s	and m	anner as s	tated.
• Hos 24 hc • Fun etely i	edical		Examiner: On the ba	isis of examination										
To th within To th	Me	29b. Signature and title of certifie	7	1		29c.	License	e number			29d. Da	te signe	d (Month,	Day, Year)
10		MI	-t7	MD		1) 3	100) ((0/	31/01	4
1	1	30. Name and address of person	who completed cause	e of death (Item	23а) (Туре	Print) 7	50	000	-11	WAY	Ceny	2-	Dr.	#430
TIX	1	>7 corty or	Flexil 6,	prietrar's Siment	Ira -	0,	ee	-n be	214,	1-11)	20	17	O	
St: Regist	ate rar	30. Name and address of person 31. Date filed (Month, Day, Year NOV 0 4	2004	free or	13	Apa	وكناكم	/						

				1 - For State Registrar	State of Ma	ryland / Depa	artment of Hertificate of L	ealth and M Death	ental Hygie	ne no.2001	. 3683n
_	,	Physici /Medio		Decedent's Name (First, Middle, Last Louis Silverman					2. Date of Death Month	Day Yeer 25, 2004	3. Time of Death
		Examir	ner	4a. Facility Name (If not institution, give Suburban Hospital 5. Social Security Number 6. Se	x 7. Age	(In yrs. last birthday)	4b. City, Town, or Bethesd If Under 1 Year Months Days		8. Date of Birth (Month, Day, Ye	4c. County of Dea Montgome: 9. Bi	ath
		Director **And *** And	578-52-6219 Usual Residence of Decedent 10a. State 10b. County	98	Yrs. 10c. City, Town or Lo	ocation		Feb 12,		aryland 10d. Inside City Limits	
		with the Ma a or 28a-f s	Director	Maryland Montgon		Bethesda	10f, Zip Code		10g.	Citizen of What C	1 Tyes 2 No
	9800	filed within 72 hours after death with the Maryland Hygiene. uther than "natural", or Items 23a or 28a-f show ont, the Medical Examiner must be molified at	d by Funerai	7420 Westlake Ter 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates:	0	20817 Was Decedent of His f Yes, specify Cuban	Specify:		SA 14. Race - Am Black, Whi Specify: Wh	
	21215-0036	d within 72 ho piene. r than "natur the Medical	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)	cation le completed) College (1-4or 5+	(Give life. L	dent's Usual Occupal kind of work done du DO NOT use retired) Attorney	uring most of workin	g 16b	Law Prac	
	Maryland	nould be filed I Mental Hyg narked othe	To Be C	17. Father's Name (First, Middle, Last) Nathan Silverman				18. Mother's Name Anne Sil	berman	den Sumame)	
	altimore, Maı	permit. Pages 1 and 2 should be filled within 7 Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "n any injury or other traumatic event, It a Medione.		19a. Informant's Name/Relationship (T) Marcia Mirman/Dau 20a. Method of Disposition X□Burial 2 □ Cremation 3 □ F	aghter Removal from State	8060 20b. Place of Dispo- cemetery, cren		Ridge Rd	, Potomac	MD 208	354 Town, State
	Baltin	permit. Pa Departmer Important any injury		*4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licens		۸ ۸	non Cemet Name and Address 800 New H	of Facility Hine	s-Rinaldi	i Funeral	
		Pnysician /Medical		23a. Part1. Enter the disease, or compleshock, or heart failure. List only of immediate Cause (Final disease or condition resulting in death)	a	he death. Do not enter. Pneumoni consequence of):		, such as cardiac or	respiratory arrest,		Approximate Interval Between Onset and Death 3 weeks
he		Examiner sictan and purial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events resulting in death) Last	Due to (or as a	consequence of):					
125/00	68760,	ficate be ex g physician ts the burial	dical	, odding in oddin, cast	Due to (or as a	consequence of);					
0	.O. Box	The law requires that the death certificate be executed that been signed by the attending physician and bage 2 should be detached for use as the burial-transit	by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at ti 9 □ Unknown	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of del Month	ivery Day Year
orils	Records, P.	w requires that been signed b should be deta	ted by PI	Part II. Other significant conditions cor	ntributing to death but	not resulting in the un	derlying cause given	in Part I.	23e. Did tobacc	_	the cause of death?
			Completed						24a. Was an autopsy performad? 1 ☐ Yes 2 ☑ I	prior to d	itopsy findings available completion of cause of 2 No
3. Werman	n of Vital	ding Physician: n. After this certific funeral director,	on: To Be	25. Was case referred to medical examiner? 1 Yes 2X No 27. Manner of Death 1 X Natural 5 Pending	lospital: Inpatient 28a. Date of Injury (Month, Day)	2 ER/Outpatient 28b. Time of Injury		4 Nuising Home	Check only one) 9 5 Residence 1d. Describe how in		sify)
iver	Division	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined		/ - At home, farm, stre	M 1 TY6	es 2 No	if. Location (Street City or Town, Sta	an <i>d Number or R</i> u ate)	ral Route Number,
Q		To the Hospital or Attenc within 24 hours after death To the Funeral Director: completely filled in by the i	Medical C	one)	sicien: To the best of ner: On the basis of e and manner state	xamination and/or invi	occurred at the time, estigation, in my opin	, date and place, an nion, death occurred	d due to the cause at the time, date a	(s) and manner as nd place, and due	stated. to the cause(s)
		(p)	> ×	29b. Signature and title of certifier	> MJ		29c. License r	D51616		ctober 25	
		Star	tė	30. Name and address of person who co Nelson Kalil, MD 31. Date filed (Month, Day, Year)		nce Philip	Dr, #327		MD 20832		
		Registra		NOV 0 4 200	4 Sener	a g	Sparker	,			

ORIGINAL

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State of Maryland / Department of Health and Mental Hygiene 00 L

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						Certif	ficate of l	Death		Reg. No.	0 7	000	•
			1. Decedent's Name (First, Middle, La	st)					2. Date of D			3. Time of	Death
	Physici	ian							Month	Day	Year		
	/Medi	cal		ine Sindori	.S					2004		9:0	O AM
	Examir	ner	4a. Facility Name (If not institution, give	re street and number)			4	b. City, Town, or	Location of Dear	th 4c. County	of Death		
			Holy Cross Hospit	:a1			S	ilver Sp	ring	Montg	omerv		
	Funeral		5. Social Security Number 6. S	Sex 7. Age (i	In yrs. last birl		Under 1 Year	If Under 24 Hrs	8. Date of Bi	rth		ice (State o	r Foreign
	Director		021 05 7207	I□M 2∏XF	,	Yrs. M	onths Days	Hours Min	Cont	20 , 1919	Count	y)	
			Usual Residence of Decedent						sept.	20, 1919	<u>riass</u>	acnus	etts
	and **		10a. State 10b. County	1	0c. City, Towr	or Location	on				10	d. Inside Ci	ty Limits
	sho	ъ.	Massachusetts		Lovino	ton						1 ☑ Yes	
	88-1-88-1	1 to			Lexing								
	it it	Director	10e. Street and Number			1	10f. Zip Code			10g. Citizen of	What Countr	у?	
	15 w		1 Militia Dr. Sui	te 9			02421			U.S.A			
	dea dea	Funeral	11. Marital Status	12. Was Decedent Eve	er in U,S.	13. Was	Decedent of Hi	spanic Origin? (Specify Yes or Norto Rican, etc.)		e - America		
0	of the	3	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give					no nican, etc.)	Віа	ck, White, e	ic.	
N N	urs a	ρ	3 ☑ Widowed 4 □ Divorced	If Yes, Give 12 Year or Dates:		1 🗆	Yes 2 No	Specify:		Specify	w Whi	t 0	
ŏ	turi	Completed	15. Decedent's E	ducation	16a.	Decedent'	's Usual Occupa	ition		16b. Kind of B			
15	n 72	et	(Specify only highest gra	ade completed)		(Give kind	d of work done d NOT use retired	ition furing most of wo)	orking			,	
7	with than	Ē	Elementary/Secondary (0-12)	College (1-4or 5+)				or Unemp		State	Gove	rnmen	t
2	her ya	ပိ	47 Fatharia Nama (Fires Middle 1 and										
Ĕ	d ot h	Be	17. Father's Name (First, Middle, Last	,				is. Mothers Na	me (First, Middle	, Maiden Surnam	10)		
Maryland 21215-0020	should be filed within 72 hours after death with the Maryland nd Mental Hyglene. It marked other than "natural", or Items 23a or 28e-f show urmatic event, the McLical Evariner must be rodilled at	2	John J. Kelly					Delia	Bett	У			
a.	2 should be filed within 72 hours after death with the Marylan and Mental Hygiene. Is marked other than "natural", or items 23a or 28e-f show termatic event, the Medical Examiner must be notified at		19a. Informant's Name/Relationship (Type, Print)	19b.	Mailing A	ddrass (Street a	and Number or R	ural Route Numb	er, City or Town,	State, Zip (Code)	
Σ	nd 2 ulth a 27 ls r tre		Arthur Sindoris/N	lephew	21	3 Pau	ıla Lynı	n Dr. Si	lver Sp	ring, MD	2090	4	
စ်	Hea Hea othe		20a. Method of Disposition		20b. Place of	Dispositio	n (Name of		Date	20c. Location -			- 0
ਠੁ	permit. Pages 1 and 2 should be Department of Health and Monta Important: If item 27 is marked any Injury or other treumatic es once.		1X Burial 2 ☐ Cremation 3 ☐		cemeter	y, cremato	ny or other place						
	OF ET P		4 ☐ Donation 5 ☐ Other (Specif	1	Westvi		emetery			04 Lexin		MA	
Baltimore,	ppar poor ny In		21. Signature of Funeral Service Licer	isee		22. Na	ame and Addres	s of Facility Hi	nes-Rina	aldi F.H	. •		
ш	202 2 3		Xan P 7/2	1-0		1180	00 New H	Hampshir	e Ave.	Silver S	pring	, MD	20904
			23a. Part. Enter the disease, or com	plications that caused the	e death. Do n	ot enter th	ne mode of dying	, such as cardia	c or respiratory a	rrest,		Approximate)
	Ohmainian		shock, or heart failure. List only	one cause on each line.								nterval Betv Onset and D	veen Death
)	Physician /Medical		Immediate Cause (Final										
	Examiner		disease or condition resulting in death)	aMyocardial	Infar	ction	n						
		<u>.</u>	resulting in south,		e to (or as a c		ce of):				1		
	D #	Examiner	122	Alzheimer'	s Dise	ase					1		
	certificete be executed inding physicien and use as the burial-transit	an	Sequentially list conditions,	Du-	e to (or as a o	onseque	ob of).						
o`	en a	ũ	if any, leading to immediate cause. Enter Underlying	Hypothyroi	dism						1		
ox 68760,	ysici e bu	n/Medical	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	C	e to (or as a c	onsequenc	ce of):	-					
89	ficel g phy as th	귷	resulting in death) Last		•		•						
×	ding ding	3		d.Gastro-eso	pnogea	ı Ke	TIUX DIS	sease					
ă	eath etter												
o	the d	Physicia	Part II. Other significent conditions of	ontributing to death but n	ot resulting in	the under	lying cause give	n in Part I.	23b. Did	tobacco use co	ntribute to t	he cause o	f death?
o.	requires thet the death seen signed by the etter hould be detached for t								1 🗆	Yes 2□ No	3 Proba	bly 4 🛣	Jnknown
	es the	ρ							-				
Hecords,	v require been si should I	Completed								an autopsy rmed?		autopsy fi able prior to	
ပ္တ		Set							, ,		comp of de	pletion of ca	ause
ř	0 - 5	Ē							40	W- OVIA			
=	icate								10	Yes 2∭ No	1 🗆	Yes 2□I	NO
VIITal	Attending Physicien: The or death. ector: After this certificate by the funeral director, pag	Be	25. Was case referred to medical examiner?	Hospital: 💥			Otho		ath (Check only	one)			
6	Physic this c	ဥ	1 ☐ Yes 2 🔯 No	1 M Inpatient	2 ☐ ER/Out			4 Li Nursing r	1	dence 6 □Oth			
_	ding P. h. Aftert funera	ü	27. Manner of Death 1 XNatural 5 ☐ Pending	28a. Date of Injury (Month, Day Ye	28b. T	ime of jury	28c. Injury Work	at ?	28d. Describe	how injury occurr	ed		
<u> </u>	Attendir death. ctor: Af by the fu	atic	2 Accident investigation			P	M 1□Y	'es 2□No					
DIVISION	Atte er de by th	iţic	3 ☐ Suicide 6 ☐ Could not be determined	286. Place of injury	- At home, far	m, street,	factory, office		28f. Location (City or To	Street and Numb	er or Rural F	Route Numb	oer,
5	il or Attend after death Director: A d in by the	Certification:	4 I Homidde	building, etc. (5	specity)				Ony or 10	wn, State)			
	To the Hospital or A within 24 hours after To the Funeral Director Completely filled in by		29a. Certifier 1 Certifying Ph	ysician: To the best of m	y knowledge.	death occ	curred at the time	e, date and place	and due to the	cause(s) and ma	nner as stat	ed.	
	Pur Fur etely	edicai	(Check only 2 Medicel Exam	niner: On the basis of exa and manner stated	amination and	/or investi	gation, in my op	inion, death occu	urred at the time,	date and place, a	and due to the	ne cause(s)	
	ithin o the	Me	29b. Signature and title of certifier	1	1		29c. License	number		29d. Date signed	d (Month, Da	y, Year)	
	F3F8		List.	Voh	0 1	1.1				_			
	3 9	5		,		9	D-202	/ 4		10/29	/ 2004		
	R		30. Name and address of person who					MD 0001	~				
	(,		Kirti Vohra MD	7710 Bradle	y Blvd	. Be	thesda,	MD 2081	. /				
1	Sta	te	31. Date filed (Month, Day, Year)	32 Registrar's	Signature		books						
	Registr	ar	NOV U 4 200	4		14	vous						

State of Maryland / Department of Health and Mental Hygieney For State Registrar 36832 Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 1830 4 nowman 2004 11 Elaine 01 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Montgomery

9. Birthplace (State or Foreign
Country

1938 Maine Grove Hospital KOCKVILL MD

If Under 1 Year | If Under 24 Hrs.
Wonths Days Hours Min. 7. Age (In vrs. last birthday 5. Social Security Number 6. Sex **Funeral** Months 1 □ M 2 🔾 F 004 36 4294 65 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County r than "natural", or Items 23s or 28s-f show the Medical Examiner must be notified at 1 ☐ Yes 2 1 No Director Md. Montgomery Gaithersburg 10e. Street and Number 10f. Zip Code 10g. Citizen of Whal Country? 20882 8808 Brink Road United States deeth 1 Funeral 14. Race - American Indian. 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Pueno Rican, etc.) 11. Marital Status Black, White, etc. hours after 1 Never Married 2 Married 1 Yes 2 No White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: 3 ₩idowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) d 2 should be filad within in and Mantal Hygiene.
7 Is marked other than "I Elementary/Secondary (0-12) College (1-4or 5+) Restaurant 8 Waitress 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be George Viola Luce Kenneth Leach 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Caithersburg, Md. 20882 19a. Informant's Name/Relationship (Type, Print) parmit. Peges 1 and 2 st Department of Health and Importent: If item 27 Is n eny injury or other traun once. Randy Snowman / Son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 Cremation 3 ☐ Removal from State Metropolitan Crem. 11/3/04 Alexandria, Va. * 4 ☐ Donation 5 ☐ Other (Specify) ²² Name and Address of Facility
Muriel H. Barber Funeral Home
P. O. Box 5038, Laytonsville, Md. 21. Signature of Funeral Service Licenses Banke 20882 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) SEPSIS /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner death certificate be axecuted burial-transil Due to (or as a consequence of) Box 68760, attending physician Physician/Medical as the l IF FEMALE use 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy for Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) P.0. detachad 9 Unknown 9 Unknown cate has been signed by page 2 should be detact Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 Tes 2 No 3 Probably 4 Punknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 Yes 2 No 2 No or Attending Physicien: 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 2 No 1 Tes 1 Inpatient 3 DOA ို 2 ER/Outpatient 5 Residence 6 Other (Specify) 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Certification: After 1 Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No after death. investigation 2 Accident filled in by the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Exampler: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the 296. Signature and title of certifie 29d. Date signed (Month, Day, Year) 29c. License numbe 11/01/2004 0061681 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9901 Medical Center Dr., Rockville, Md. 20850 Hobert D. Kirkcaldy MD Registrar's Signature

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

NOV 04 2004

Ryan Todd Stowers 04-06978 RPD

Please Type or Print in Black Indelible Ink Figure All Copies Are Legible

)6	978		For	-	ryland / De	oartment o	f Health an	d Mental Hyg	_	36833		
			State Registrar		C	ertificate o	of Death		leg. No.	3. Time of Death		
	Physicia		Decedent's Name (First, Middle, Last)			_		2. Date of Dea Month	Dav Year			
	/Medic	al .	RYAN	TODD	STOWER			Octobe		0915 P ^M		
	Examin	er	4a. Facility Name (If not institution, give sti Suburban Hospital	reet and number)		Bethes	m, or Location of D cda	Death	4c. County of Death Montgomery			
				7 Ago	(In yrs. last birthda			Hrs. 8 Date of Birth				
	Funeral Director		5. Social Security Number 6. Sex 127	M 2□F 7. Age	20 Yrs.			Hrs. 8. Date of Birth (Month, Day JULY 11	Year) Cour.	plece (State or Foreign ntry) IFORNIA		
	ъ.		Usual Residence of Decedent		10c. City, Town or	1				10d Inside Circle Limite		
	anylar	_	10a. State 10b. County							10d. Inside City Limits N☐ Yes 2 ☐ No		
	8a-f	Director	CA. SHASTA			REDDING			10g. Citizen of What Cou			
	's after death with the Maryland ', or Itema 23a or 28a-f show		10e. Street and Number			10f. Zip Coo				itty:		
	a 23	srai	2957 WEST WAY	2. Was Decedent E	ver in IIS 1		of Hispanic Origin	2 (Specify Yes or No-	U.S.A.	can Indian.		
	ltern Item	ű	11. Marital Status 12 Never Married 2 Married 12	Armed Forces?	0	If Yes, specify (Cuban, Mexican, P	? (Specify Yes or No- Puerto Rican, etc.)	Black, White,			
5	hours after tural, or Ita	by	3 ☐ Widowed 4 ☐ Divorced	TY□Yes 2□N If Yes, Give Year or Dates:	DUTY	1 ☐ Yes 2 ☐	No Specify:		Specify: WH	IITE		
ş	2 hou	Completed by Funeral	15. Decedent's Educa	ation	16a. De	cedent's Usual Oc	ccupation one during most of	functing	16b. Kind of Business/In	idustry		
7	within 72 ene. than "nef	pje	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5-	life	. DO NOT use re	etired)	Working				
7		Con	12			U.S. N			DEFENS	E		
Maryland 21215-0036	sal Hygi d other svent, I	Be (17. Father's Name (First, Middle, Last)				18. Mother's	Name (First, Middle,	· ·			
<u>X</u>	should bind Ment a marked	ပ္			WERS			TRICIA L.				
ā	s 1 and 2 should f Health and Mer item 27 Is marke other traumatic		19a. Informant's Name/Relationship (Typ						r, City or Town, State, Zij) Code)		
	and lealth m 27 her ti		TRICIA L.STOWERS/	MOTHER	295 20b. Place of Dis			OING, CA. 9	96002 20c. Location - City or To	own State		
0	Pages 1 nent of H int: If ite		20a. Method of Disposition 1 ▼Burial 2 □ Cremation 3▼Pe	moval from State	cemetery, c	rematory or other	place)					
	tant:		* 4 ☐ Donation 5 ☐ Other (Specify)		LAWN C			ov.10,2004	REDDING,	CA.		
Baltimore,	permit. Pages 1 Department of H Important: If ite any Injury or otf		21. Signature of Funeral Service Vicenses	hunder	2100001	CHAMBERS	ddress of Facility FUNERAL	HOME & CF	REMATORIUM,	P.A.		
			23a Part 1 Enter the disease or complic	ations that caused	MUUU91 the death. Do not i	5801 CLE	CVELAND A	VE., KIVER	RDALE, MD. 2	Approximate Interval Between		
r			23a. Part1. Enter the disease, or complice shock, or heart failure. List only one	cause on each lin	е.	1	100		/	Interval Between Onset and Death		
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death) a. Out the form of the condition of the c									
ı	Examiner			Due to (or as a	consequence or).	,						
	\$.	F G	Sequentially list conditions, if any, rading to immediate									
	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.									
<u>,</u>	be executed ician and burial-transit	Exa	resulting in death) Last	Due to (or as a	consequence of):							
200	0 8	cai	d.									
9	tificat ig phy as th	edi								-		
ŏ	h cer endin	J/N	23b. was decedent pregnant	lc. If yes, outcome of		3 □Ectopic pregn	ancv		23d. Date of deliv	*		
	deat	sicie	in the past 12 months? 1 Yes 2 No	4☐Pregnant at		5 Other (specif			Month	Day Year		
P.O. Box	that the death certificat ed by the attending phy detached for use as th	Physician/M	9 Unknown					Dog Didge		ab a server of death?		
	The law requires that the death certifica ate has been signed by the attending ph bage 2 should be detached for use as th	by	Part II. Other significant conditions cont	ributing to death bu	it not resulting in the	underlying caus	e given in Pan I.		bacco use contribute to t 'es 2□No 3□Prol	s.J		
Vital Records,	requi	ompleted						- 1				
ec	e law has b je 2 sł	npie						24a. Was autop	sy prior to co	opsy findings available ampletion of cause of		
=	The l	So							2 No 1 Yes	2 No		
/ite	Physician: Th r this certificate ral director, pag	Be	25. Was case referred to medical examiner?	ospital:			Other	f Death (Check only or				
	Physic this c	2	X Yes 2 No	1 Inpatie			4 114013	1	ence 6 Other (Speci. ow injury occurred	(y)		
Sn (ling f	lon	27. Manner of Death 1 Natural 5 Pending	(Minth, Day	Year) Injur		Injury at Work?	, ,	+ dat			
Sic	Attending in death. ector: After by the fune	icat	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Inju	ary - At home, farm,			000	treet and Number or Rug	al Route Number.		
Division of	or A after Direction by	Certification:	4 Homicide determined	building, etc	. (Specify)	Street, factory, or	1100	City or Tow	m, State) 11844 R	sckoylle Pila		
	s Hospital or Attending I 24 hours after death. 9 Funeral Director: After etely filled in by the funer		29a. Certifier 1 ☐ Certifying Phys	ician: To the best of	of my knowledge, de	eath occurred at the	he time, date and i	place, and du to the o	ause(s) and mar ner as s	stated.		
	24 hos Prun etely	edicai	(Check only 2 Medical Examin	er: On the basis of	examination and/o	investigation, in	my opinion, death	occurred at the time, o	date and place, and due t	o the cause(s)		
	To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Me	29b. Signature an little of certifier	14-		29c. Li	cense number		29d. Date signed (Month,	Day, Year)		
			1/hd 11	King	trio -	0.0	C.M.E.		October 29,	2004		
	9+1		30. Name and address of person who cor	npleted cause of de	eath (Item 23a) (Ty	pe, Print)	Ohan at 1	7-14	Manual 3 02	201		
_	TR		THE SPORE M. King	60.5				odrumore,	Maryland 21	.201		
	Sta Regist		31. Date filed (Month, Day, Year) NOV 0 4 200		ar's Signature	Space	Kar					
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Registrar DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiens 36834 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** October 2004 25, 3:25 A M Diane Byrd Subero /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Montgomery Shady Grove Adventist Hospital Rockville If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex 1 □ M 2 🖾 F Yrs 212-33-3092 65 08/16/1939 Virginia Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 X No Director MD Gaithersburg Montgomery 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 18455 Lost Knife Circle, Apt. 104 20886 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 | Yes 2 | No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: White þ 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Clarence M. Gee Byrd James 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20886 Lennox A. Subero, Spouse 18455 Lost Knife Cir, Apt. 104, Gaithersburg, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Ft. Lincoln Crematory 11/01/2004 Brentwood, Maryland ' 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Simple Tribute 21 Signature of Fund a Serv 1040 Rockville Pike, Rockville, Maryland 20852 23a. Part 1. Enter the diseast, or complications that cause of the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each lin. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Asystolic Arrythmia Minutes Due to (or as a consequence of): Seizure Disorder Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): Completed by Physician/Medical 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? 2 □ No 1 🗌 Yes **2**₹ No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2**X** No 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 1 X Naturai 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 4 T Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Mann November 2, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Medical Center Drive, Rockville, Maryland 20850 Aron Snyder, MD, 9901 31. Date filed (Month, Day, Year) 32. Registrar's Signature State NOV 04 2004 Registrar

DHMH 17 Rev 1/200

Funeral

Director

28a-f show

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Division of Vital Records, P.O.

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Baltimore, Maryland 21215-0036

State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Dav Year **Physician** 7:00 NOVEMBER 10, 2004 ERNEST WARREN SHAFFER /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner GARRETT DENNETT ROAD MANOR NURSING HOME OAKLAND 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 6. Sex Birthplace (State or Foreign Country) 5, Social Security Number **Funeral** Hours Days 1 X M 2 □ F WV 87 Yrs. 20, 213-12-9379 SEPT Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 28a-f show the Medical Examiner must be notified at 1X Yes 2 □ No MT. LAKE PARK Director **GARRETT** MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 23a or USA APT.#9 21550 815 DEER PARK AVENUE or Items Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? permit. Pages 1 and 2 should be filed within 72 hours after a Department of Health and Mental Hygiene. Importent: if item 27 is marked other than "naturel", or Iter any injury or other traumatic event, the Medical Examinat once. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 TNO Specify: ģ WHITE 3 X Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done di life. DO NOT use retired) during most of working Elementary/Secondary (0-12) College (1-4or 5+) CONSTRUCTION MANAGER CONSTRUCTION 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be VIRGINIA WILSON CARRIE TEWALT SHAFFER DAVID 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) AURORA, WV 26705 HC82 BOX 7 JUDY PAUGH - DAUGHTER-IN-LAW Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 Cremation 3 Removal from State 11/13/2004 AURORA, WV AURORA CEMETERY * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature o Funeral Service 22. Name and Address of Facility P.O. BOX 243 DURST FUNERAL HOME - OAKLAND, MD 21550 M00167 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** ACUTE LEUKEMIA /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, it among to immorphise cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 DUnknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? been signe should be ð 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No page 2 After this certificate has 1 Yes 2 💢 No To the Hospitel or Attending Physicien: within 24 hours after death.

To the Funerel Director: After this certifics completely filled in by the funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 1 ☐ Yes 2 ☐XNo 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification; To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 5 Pending investigation 1 X Natural 1 ☐ Yes 2 ☐ No М 2 Accident 6 Could not be determined 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 X Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medical 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier H26154 NOVEMBER 11, 2004 Hem Drees 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 69 WOLF ACRES DRIVE OAKLAND, MD 21550 P. DANIEL MILLER, D.O. 31. Date filed (Month, Day, Year) NOV 1 2 32. Registrar's Signature State 2004 Registrar

			1 - For State Registrer	State of Ma	ryland		artment of F		and M		ene g. No. 20	04	36836
			Decedent's Name (First, Middle, Las	")						2. Date of Death		V	3. Time of Death
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	Examin		4a. Fecility Name (If not institution, give				4b. City, Town, o	r Location o	of Death		4c. County	of Death	
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	Funeral			x 7.Age ⊒M 21⊠F		ast birthday) Yrs.	If Under 1 Year Months Days	If Under:	Min.	8. Date of Birth (Month, Day,			place (State or Foreign ntry)
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	238	la l	3771 Gorman Road					1550				USA	
	er des	Funeral	11. Marital Status	12. Was Decedent E Armed Forces?		S. 13.	Was Decedent of H f Yes, specify Cuba	lispanic Ori an, Mexican	gin? (Spe n, Puerto F	cify Yes or No- Rican, etc.)		e - Americ ck, White,	
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Baltimore, Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural; or items 23a or 28a-f show any injury or other traumatic event, I.a. Medical Evaluitation in williad at ance.		20a. Method of Disposition		20b. PI	lace of Dispo	sition (Name of				0c. Location -		
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<u>.</u>	e deal	sici	in the past 12 months? 1 □ Yes 2 D No	4□Pregnant at 9□Unknown	time of de	eath 5	Other (specify)				Мо	riui	Day Year
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Division of Vital Records,	l or Attendater death Director:	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Inju- building, etc	iry - At ho :. (Specify	me, farm, str /)	eet, factory, office		2	8f. Location (Stre City or Town,		er or Rura	I Route Number,
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	To the Within To the	Me	29b. Signature and title of certifier	1 . 1 /	· .		29c. Licens	e number		29	d. Date signed	d (Month,	Day, Year)
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	>		30. Name and address of person who	completed cause of de	eath (Item	23a) (Type,	Print)	1 /	2		10		1-
1	8		margaret at	laiser m	d	1307	9 garret	t his	uwa	y car	Kleins	,ua	21550
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State of Maryland / Department of Health and Mental Hygiene 2004 1 - State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year **Physician** Melodia Smith November 2004 2 /Medical 4b. City, Town, or Location of Death Clinton 4c. County of Death
Prince George 4a. Facility Name (If not institution, give street and number) **Examiner** Bradford Oaks Nursing Home 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Days Months Hours 1□M 2€1F 86 Vre Feb. 9, Florida 1918 Director 375-12-19:02 Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County item 27 is marked other than "natural", or itams 23a or 28a-f show other traumatic event, it a M. of all Examples must be notified at Temple Hills 1 XIYes 2 □ No MD Prince George Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20748 USA 4311 23rd Parkway, #1002 Funerai 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerlo Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black White etc. is 1 and 2 should be filed within 72 hours after of Health and Mental Hygiene. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 XNo Specify: Baltimore, Maryland 21215-0036 Specify: Black þ 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Educational System Pre-School Teacher 12th 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Melodia Smith Amos Hanes 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 5407 Old Temple Hill Rd, Temple Hills,MD 20748 Dorothy Barnes/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of H
Important: If ites
any Injury or oth 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Lincoln Memorial 11/6/04 Suitland, MD 21. Signature of Funeral Service Lic Insee 22. Name and Address of Facility Strickland Funeral Services 6500 Allentown Rd, Camp Springs, MD 20748 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Dhoummy /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Clear of Figure 1) that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical use as the IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day ō in the past 12 months?
1 Yes 2 No 5 ☐ Other (specify) 4 Pregnant at time of death the detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ page 2 should be 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐ Yes 2 ☐ No 25 No 25. Was case referred to medical examiner? To the Hospital or Attanding Physician: director, Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other 1 ☐ Yes 2 No 4 Nursing Home 5 Residence 6 Other (Specify) 2 this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 Natural 5 Pending investigation after death. 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 24 hours after of Funaral Dirac 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Nevember 3, 2004 D35206 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Part WAKKIngton TANNER m 11701 LiVingitin Road 31. Date filed (Month, Day, Year) . Registrar's Signature State NOV 0 8 2004 Registrar

DHMH 17 Rev 1/200

			1 - For State Registrar	State of Ma	ryland / Depa	artment of F			ene	. 36838
	Physic	an	1. Decedent's Name (First, Middle, Las))	-			2. Date of Death Month		3. Time of Death
	/Medi		Russell Willia		th			November	Day Ye 3, 2004	4:00 a M
4	Examir	ner	4a. Facility Name (If not institution, give				r Location of Death	1	4c. County of D	
			706 Chesapeake 5. Social Security Number 6. Se		(In yrs. last birthday)	Silver If Under 1 Year	Spring If Under 24 Hrs.	9 Data of Birth	Montgo	
	Funeral Director			3 £M 2□F	81 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, Oct. 6,		Birthplace (State or Foreign Country) shington, DC
	yland		10a. State 10b. County		10c. City, Town or Lo	cation				10d. Inside City Limits
	Mar Me-f st	tor	Maryland Montgon	nerv	Silver S	pring				1 ☐ Yes 2 🔀 No
	or 28	Director	10e. Street and Number			10f. Zip Code		10	g. Citizen of What	Country?
	ath w	ral	706 Chesapeake	Avenue		20910			USA	
	er de	Funeral	11. Marital Status	12. Was Decedent Example Forces?	ver in U.S. 13.	Was Decedent of H f Yes, specify Cuba	lispanic Origin? (Sp an, Mexican, Puerto	pecify Yes or No- Rican, etc.)		merican Indian, /hite, etc.
36	rs aft	by F	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	1 ⊠Yes 2 □ No If Yes, Give 1 Year or Dates:)	1 ☐ Yes 2 🛣 No	Specify:			White
21215-0036	72 hours after death with the Maryland natural', or Items 23a or 28e-f show disal Examiner must be notified at		15. Decedent's Edi	ucation		dent's Usual Occup	ation	1	6b. Kind of Busine	ses/Industry
215	within 73 ene. then n	ple	(Specify only highest grad	de completed) College (1-4or 5+	(Give	kind of work done DO NOT use retired	during most of worl	king	ob. Iting of busine	Samuastry
21	filed with Hygiene. Ither ther	Completed	12	0011098 (1 401 51	·	penter			U.S. Gove	ernment
nd	0 = 0 >	Be (17. Father's Name (First, Middle, Last)				18. Mother's Nam	e (First, Middle, M	aiden Sumame)	
<u></u> ₹	should ind Men in marke	၉	Russell Austin		7			gnes Naug		
Maryland	ages 1 and 2 should b ont of Health and Ments it: If item 27 is marked y or other treumatic e		19a. Informant's Name/Relationship (T					ral Route Number,		
	1 and Healt em 2		Catherine A. Smit	n/ Wife	20b. Place of Dispo	sition (Name of		, Silver	Spring, Oc. Location - City	
Baltimore,	Pages nent of I int: If its		1 ₺ Burial 2 □ Cremation 3 □ I		Poplar S	natory or other plac Springs	Novem	iber 6, P	oplar Sp	
Ė	i fi fi		 4 □ Donation 5 □ Other (Specify, 21. Signature of Funeral Service Licens 		United Meth	Mame and Address	ch Cemeterv	M	aryland	
ä	Depa Impo any ii		1	la	Fr	rancis J. 00 Univer	Collins sity Blv	Funeral 1. W. Sil	Home Inc	ng, MD 20901
			23a. Part1. Enter the deease, or comp shock, or heart failure. List only o Immediate Cause (Final	ne cause op each line	he death. Do not ente e.	er the mode of dyin	g, such as cardiac	or respiratory arres	et,	Approximate Interval Between Onset and Death
	Pnysician /Medical		disease or condition resulting in death)	a Arrhyth:	mias consequence of):					1 Days
В	Examiner			Coronar	y Artery D	Disease				5 Months
	n =	ner	if any, leading to immediate cause. Enter Underlying		consequence of):					110.11011
	and and trans	Examine	Cause (Disease or injury	c. Hyperte						6 Months
8760,	icate be executed physician and s the burial-transit	E	resenting in death) East	Due to (or as a	consequence of);					
687	death certificate be executed e attending physician and id for use as the burial-transit	edical		d						
×	eath certific attending p	/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of	pregnancy				22d Date of	dolivon
Box	death e atte	Physician/M	in the past 12 months?	1 ☐ Live birth 2 4 ☐ Pregnant at tir		Ectopic pregnancy Other (specify)			23d. Date of o Month	Day Year
		hys	9 Unknown	9□ Unknown						
S, D	requires that the een signed by th nould be detache	by P	Part II. Other significant conditions co		not resulting in the un	iderlying cause give	en in Part I.	23e. Did toba	cco use contribute	to the cause of death?
ord	w requir been si should I		Congestive Heart	Failure				1 ☐ Yes	2 1 No 3 □	Probably 4 Unknown
Vital Record	law as b 2 si	Completed						24a. Was an autopsy	prior t	autopsy findings available o completion of cause of
E		Con						performe 1 ☐ Yes 2 ☐	d? death	?
Vit.	Physicien: 7 this certifica ral director, p	Be	25. Was case referred to medical examiner?	Hospital:		Oth		h (Check only one)		
ō		. To	1 X Yes 2 No 27. Manner of Death	1 Linpatient	2 ER/Outpatient		4 Nursing Ho	me 5 X Residence 28d. Describe how		pecify)
on	Attending Pt r death. actor: After th by the funeral	tion	1 X Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day)	Year) Injury	28c. Injury Work M 1 🗀	(?Î Yes 2 □ No	EDG. DOSCHOO HOW	injury occurred	
	f or Attency after death Director: in by the	ertification;	3 Suicide 6 Could not be determined	28e. Place of Injury	y - At home, farm, stre			28f. Location (Stre	et and Number or	Rural Route Number,
Ö	spitaf or At ours after of serel Directification by	Cert	4 🗆 Homicide	building, etc.	(Specify)			City or Town,	State)	
	A T T F	edical	29a. Certifier 1⊠ Certifying Phy (Check only one) 2 Medical Exami	sician: To the best of ner: On the basis of e and manner state	xamination and/or inv	occurred at the time estigation, in my op	ie, date and place, pinion, death occuri	and due to the caused at the time, date	se(s) and manner and place, and d	as stated, ue to the cause(s)
	To the within 2 To the complet	Σ	29b. Signature and title of certifier	A. A	221	29c. License		29d	. Date signed (Mo	. ,
F	v	0	Flomy P. Kan			D20	002		November	3, 2004
_	10		30. Name and address of person who con Tony P. Kannarka	mpleted cause of dea	ith (Item 23a) (Type, F 201 16th S	rint) treet, S	ilver Spr	ing, MD 2	20910	
	Sta Registr		31. Date filed (Month, Day, Year) NOV 0 5 200	32. Registrar's	s Signature	Sparks	*			

	_		1- State of Maryland Department of Health and I Registrar Certificate of Death			04	36839
	Physic	an	1. Decedent's Name (First, Middle, Last) Denise L. Spady	2. Date of D	Day 2004	Year	3. Time of Death
	/Medi Examir		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death	NOV.	14 2004 4c. County		0119 A M
~	Exami	lei	FORT WASHINGTON HOSPITAL FORT WASHINGTO		1		EORGES
X	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.				lace (State or Foreign try)
3	Director		579 86 2367 43 Yrs. Usuel Residence of Decedent	02/0	irth Pay, Year) 02/61	Wasi	nington, D
	show	-	10a. State 10b. County 10c. City, Town or Location			1	Od. fnside City Limits
	the M	Director	DC Washington 10e. Street and Number 10f Zin Code				1X Yes 2 No
	with Ba or	ij	106. Street and Number 106. Zip Code 20032		10g. Citizen of V		try?
	death	Funerai		pecify Yes or N		e - Americ	an Indian
920	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "naturel", or Items 23a or 28e-f show any injuryer other traumetic event, the Medical Examment in items to indiffer a page.	by	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced 12. Was Decedent of Hispanic Origin? (Sr. If Yes, specify Cuban, Mexican, Puerto If Yes, Give Year or Dates:	o Rican, etc.)	Specify	ck, White,	etc.
2-0	72 ho	ted	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of won	de la c	16b. Kind of B		
Baltimore, Maryland 21215-0036	ed within giene. er then "o	Completed	Elementary/Secondary (0-12) Colfege (1-4or 5+) Special Police	KING	Gover	nmer	nt
land	uld be file Jental Hy rked oth tic event	To Be (Gennelieus G. 2	ne (First, Middle i Ridd	a, Maiden Suman ick	ne)	
an	2 sho and h Is ma	ľ	19a. Informant's Name/Relationship (Type, Print) 19b. Maifing Address (Street and Number or Ru.	ral Route Numb	oer, City or Town,	State, Zip	Code)
≥ ~	and ealth m 27			T. a	ton,DC	2003	32
imore	mit. Pages 1 partment of H cortent: If ite injuryer ott		20a. Method of Disposition Disposition Community Disposition Community Disposition Community Disposition Community Disposition (Name of cemetery, crematory or other place) Harnmony Memorial 11,	Date / 20 / 04	Landov	•	
Balt	permit. Departr Imports any inj		21. Signature of Funeral Service Licensee \$2. Name and Address of Facility Ho 5732 Georgia Ave	ome&Cr	emation	Ser	vice
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or head allure. List only one cause on each line.	or respiratory a	asningt arrest,	1	Approximate
	Physician	V.	Immediate Cause (Final disease or condition Cardiac Arrhythmia				Interval Between Onset and Death
	/Medical Examiner		resulting in death) Due to (or as a consequence of):				
- 10	Ladillilei	h.	Sequentiafly list conditions, b.				
	bed nsit	Examiner	Sequentiafly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury				
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З, Р	res that igned b be deta	y Pł	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did t	obacco use contr	ibute to the	cause of death?
ord	w require been sig should b	ted t		1 🗇	Yes 2 No	3 🗌 Proba	bly 4 □Unknown
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ital	sicien: Th certificate rector, pag	Be C	25. Was case referred to medical 26. Place of Deat	h (Check only o		TI Yes 2	P No
	hysic nis ce I direc	To	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other. 4 Nursing Ho	ome 5 🗆 Resi	dence 6 Othe	ar (Specify)	
Division of	utending Physicien: The lav death. ctor: After this certificate has y the funeral director, page 2	ation:	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation 28a. Date of Injury (Month, Day Year) 28b. Time of Injury Work? M 1 Yes 2 No	28d. Describe	how infury occurre	ed	
Divis	el or Attences after death	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (City or To	Street and Number wn, State)	er or Rural	Route Number,
	To the Hospitel or Attend within 24 hours after death To the Funerel Director: completely filled in by the	Medical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.	and due to the red at the time,	cause(s) and mar date and place, a	nner as sta and due to t	ted. he cause(s)
	To th withir To th comp	Me	29b. Signature and title of certifier 29c. License number		29d. Date signed		
	3		Moharite The Shall My O.C.M.E		NOV.	14, 2	004
	N	~	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MANUAL 111 Penn Street, Baltimore	re. Mar	vland 21	201	
Г	Sta Registr		31. Date filed (Month, Day, Year) 32. Degistrar's Signature Sparks	-,			

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	Physici		Decedent's Name (First, Middle, Las ROSE	TENNANT	SI	MITH		2. Date of De Month NOV •	Day	Year	3. Time of Death 3:30 AM		
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	and and		Usual Residence of Decedent 10a. State 10b. County	10c. C	ity, Town or Locat	tion				10d	. Inside City Limits		
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	r 28a	<u>ie</u>	10e. Street and Number			10f. Zip Code			10g. Citizen of	What Country	?		
	th with	a D	4337 Madonna F	Road			21154		Unit	ed St	tates		
020	be filed within 72 hours after death with the Maryland ital Hygiene. d other than "natural", or items 23a or 28a-f show event, the Mcdoal Expredient mast be notified at	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		s Decedent of Hes, specify Cuba	lispanic Origin? (Spe an, Mexican, Puerto Specify:	ecify Yes or No Rican, etc.)	14. Rad Blad Specify	ce - American ck, White, etc			
Maryland 21215-0020	thin 72 hours after. e. an "natural", or Medical Exert	Completed	15. Decedent's Edi (Specify only highest grad Elementary/Secondary (0-12)	ucation de co <i>mpleted)</i> College (1-4or 5+)	16a. Deceden (Give kin- life. DO	t's Usual Occup d of work done NOT use retired	ation during most of worki d)	ing	16b. Kind of B				
121	filed with Hygiene. ther than	Con	11	0	I	Farm W			Home		ming		
ano		Be	17. Father's Name (First, Middle, Last)		Mannar	.+	18. Mother's Name		Maiden Surnan	,			
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	d2.9 thar 7 Is trau		Douglas H. Smi			Madon			et, Md		L 1 54		
ē,	is 1 and 3 of Health Item 27 I		20a. Method of Disposition	20b.	Place of Disposition	on (Name of		Page	20c. Location -				
E	Pages nent of I nt: If Ite		1 ABurial 2 ☐ Cremation 3 ☐ I 4 ☐ Donation 5 ☐ Other (Specify,	Hemovai from State	-	emeter		2004	Madonn	a. Ma	ryland		
Baltimore,	permit. Page: Department of Important: If I any Injury or once.		21. Signature Ameral Service Licens		22. N E	ame and Addre	ss of Facility	on Fun	eral H	ome,			
			23a. Part 1. Enter the disease, or comp shock, or hear failure. List only of	lications that caused the dea	th. Do not enter to	he mode of dyin	sville, g, such as cardiac o	r respiratory a	rest,	21084 Ar	oproximate		
San San San San San San San San San San	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	a. CORONAR	Y ARTE	RY DIS				Int Or	terval Between nset and Death		
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Division of Vital Records,	sw requires s been sigr 2 should be	Completed by						24a. Was perfo	an autopsy rmed?	availal	autopsy findings ble prior to letion of cause th?		
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Sion	andin aath. or: Aft he fur	atio	1 🕅 Natural 5 ☐ Pending investigation	(World, Day 1 Sary			Yes 2 □ No						
Divis	tal or Atters efter de el Directo	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At h building, etc. (Special	ome, farm, street, fy)	factory, office	2	28f. Location (5 City or Tow	Street and Numb m, State)	er or Rural Ro	oute Number,		
	To the Hospital or Attending Phys within 24 hours efter death. To the Funeral Director: After this completely filled in by the funeral di	edical	29a. Certifier 1 Certifying Phy 2 Medical Exemi	sician: To the best of my kno ner: On the basis of exemina and manner stated.	owledge, death ocation and/or invest	curred at the timing ation, in my or	ne, date and place, a pinion, death occurre	and due to the d ad at the time, d	cause(s) and ma date and place, a	nner as state and due to the	d. e cause(s)		
	With Total	Σ	29b. Signature and title of certifier	m-11		29c. License	e number	-	29d. Date signed	l (Month, Day	', Year)		
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	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's Signa		parts							

DHMH 16 Rev 6/95

State of Maryland / Department of Health and Mental Hygier 00

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	Physici		MARTHA	MARI	KLINE	C	SPICE	7.	Nov •	15. 20	Year 004	12:40 PM				
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					ge (In yrs. lest birth	nday) If Un	der 1 Year									
	Funeral Director			1□M 2 F		rs. Month	hs Deys	Hours Mir	8. Date of Bi (Month, Di	1952	Coun	lece (State or Foreign try) ryland				
R	Director		Usual Residence of Decedent) to				2/11/	17/2	Ma	Tyrand				
	and and		10a. State 10b. County	Andrew Comments	10c. City, Town	or Location					10	0d. Inside City Limits				
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	£ 5 8	百				TOT.	Zip Code	03.00								
	ath v	rai	4046 Hunt Cr	-				21084				States				
	eb neme	nu-	11. Marital Status	12. Was Decedent Armed Forces? 1 ☐ Yes 2	Ever in U,S.	13. Was De If Yes, s	ecedent of H specify Cuba	lispanic Origin? (an, Mexican, Pue	Specify Yes or No rto Rican, etc.)	- 14. Hac	e - Americ k, White, e					
0	afte	F	1 Never Married 2 Married	1 ☐ Yes 2 If Yes, Give Year or Detes:	No	1 ☐ Yes	s 2 X No	Specify:		Specify	r 141	no i to				
ő	ours	qp	3 ☐ Widowed 4 ☐ Divorced	Year or Detes:						, ,	W.	hite				
21215-0020	within 72 hours after death with the Maryland ene. than 'natural', or items 23a or 28a-f show then Modical Examinar must be notified at	Completed by Funeral Director	15. Decedent's l (Specify only highest g	Education rade completed)	16a. [Decedent's U (Give kind of	work done	oation during most of w d)	orking	16b. Kind of Bu	siness/Ind	lustry				
2	ithin	du	Elementary/Secondary (0-12)	College (1-4or	5+)				_							
	ar th	Ö	12	2]	House	ewife			Home)				
b	Safe F	Be	17. Father's Name (First, Middle, Las	st)				18. Mother's Na	ame (First, Middle	, Maiden Surnam	10)					
<u>la</u>	Alenta Alenta rked ric a	T P	Ross Edwa	ird M	arkline	9		Emma	a Elm	ira	Sutt	on				
Maryland	12 should be filed within hand Mental Hygiene. I is marked other than 'traumatic avant, the Mes	-	19a. Informant's Name/Relationship	(Type, Print)	19b.	Mailing Addr	ess (Street	and Number or F	Rural Route Numb	er, City or Town,	State, Zip	Code)21084				
	ges 1 and 2 should be filed within 72 hours after death with the Marylar It of Health and Mental Hygiene. If item 27 is marked other than "natural", or Items 23a or 28a-f show or other traumatic avant, the Medical Examinar must be notified at		Ralph W. Spic	e/Husban	d 404	46 Hu:	nt C	rest Re	d. Jar	rettsv	ille	, Md.				
ē,	s 1 and 3 f Health tem 27 i		20a. Method of Disposition		20b. Place of I	Disposition (/	Name of	20)	7 7Dates 6	20c. Location -	City or To	wn, Stete				
no.	ages onto		1 Burial 2 □ Cremation 3 4 Donation 5 □ Other (Spec	Removal from State					2004	Hanoure	y M	laryland				
Baltimore,	permit. Pages 1 and 2 Department of Health a Important: If item 27 Is any Injury or other tra once.				COMY G											
Ba	Depari Depari Impor any Ir		21.391.00	Anatomy Gifts Registry 2004 Hanover, Maryland 1. Signature of Funeral Service Licensee 22. Name and Address of Facility E.G. Kurtz & Son Funeral Home, P.A. Jarrettsville, Maryland												
			1. Jelleich	den / w	43-	Jar	rett:	sville.	. Marvl	and		,				
			23a. Part1. Enter the disease, or con shock, or heart failure. List onl	n. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death												
Y	Physician			Onset and Death												
4	/Medical		Immediate Ceuse (Final disease or condition	ease or condition within in the stage unal disease												
	Examiner		resulting in death)	ase or condition												
10.7	,	ne		s .							1					
11	cute	В	Sequentially list conditions, Due to (or as a consequence of).													
oʻ	a exe an a urial-l	ŭ	Sequentially its, conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events								İ					
68760,	te be ysici	ical	that initiated events resulting in death) Last	C	Due to (or as a co	onsequence o	of):									
89	certificate be executed nding physician and use as the burial-transit	Physiclan/Medical Examiner	resulting in death) cast								İ					
ŏ		2		d							- -					
B	d for i	icia	Part II. Other significant conditions	contributing to death h	out not resulting in	the underlyin	n cause niv	en in Part I	23b. Did	tobecco use coi	atribute to	the cause of deeth?				
P.0	the o	hys	Takin other algimouni odhululla	contributing to double	at not resulting in	are arracityiir	ig outdoo giv	on area.				pably 4 Unknown				
	The law requires that the death ate has been signed by the atte page 2 should be detached for	<u>P</u>							. "	168 212 140	0[]1100	ably 4 onknown				
Records,	sign sign ld be	d by							24a. Was	an autopsy	24b. We	ere autopsy findings				
Ö	requ Deen shou	ete							perfe	rmed?	cor	eilable prior to inpletion of cause				
š	e law has l	Completed									of c	déath?				
7	The pag	ខ							10	Yes 2⊡No	1	Yes 20 No				
of Vital	Physician: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?						eth (Check only			-				
=	Physic this co	2	1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ Inpati	ent 2□ER/Outp	petient 3□	DOA Oth	er: 4□ Nursing	Home 5 Resi	dence 6 □Oth	er (Specify	"				
0	ng PI ter th	Ë	27. Menner of Death 1 ☑ Natural 5 ☐ Pending	28a. Dete of Inju (Month, Da	ury 28b. Ti ay <i>Year)</i> Inj	me of jury	28c. Injur Wor	y et k?		how injury occurr						
<u>.</u>	Attending or death. ector: After by the fune	atic	2 ☐ Accident investigati	on		М		Yes 2 □ No								
Division	Atte or de octo by th	IIIC	3 ☐ Suicide 6 ☐ Could not determine	d 200. Place of in	jury - At home, farr c. (Specify)	m, street, fac	tory, office		28f. Location (City or To	Street and Numb	er or Rurai	l Route Number,				
Ö	a after	Seri	4 E Monitolo	bullariy, et	ic. (opeany)				ony or 10	, 0.0.07						
	splta hours nera y fille	edical Certification:	29a. Certifier 1 Certifying P	hysiclan: To the best	of my knowledge,	death occurr	ed at the tin	ne, date and plac	e, end due to the	cause(s) and me	nner as st	ated.				
	na Ho na Fu) Di	(Check only 2 Medical Exa	aminer: On the besis of end manner st		or investigat	tion, in my o	pinion, death occ	surred et the time,	date and place,	and due to	the cause(s)				
	To the Hospital or Attending Physician: The is within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	M	29b. Signature end title of certifier	2/-1			29c. Licens		7	29d. Date signed						
	. 210		Lambs	Welson	Sur			6 5 5	7	11/15	104					
			30. Name end address of parson who	o completed cause of	deeth (Item 23a) /T	[vpe, Print) /		21 0	0	144 3 .	n / =					
	13		30. Name end address of person who	m, mi	04 Em	mor t	on K	d, Isel	14.1.1	VID CI	0/3					
		ato.	31. Date filed (Month, Day, Year)		rer's Signature	,	-	ч								
	Sta Registr		NOV 1 9	2004 22	per e	9	Local	21								

State of Maryland / Department of Health and Mental Hygiene 0 1

Physician
/Medical
Examiner

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "neturel", or Items 23a or 28a-f show eny Injury or other traumatic event. In Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

	1 - State Registrar	$C\epsilon$	ertificate of D	Death		Reg. No.	U 4	36842
	Decedent's Name (First, Middle, Last)				2. Date of De			3. Time of Death
an	GEORGE HOMER SIMPSON				Novembe	er 5. :	Yeer 2004	5:40 A M
al er	4a. Fecility Name (If not institution, give street and number	r)	4b. City, Town, or I	Location of Death			nty of Death	
	Memorial Hospital		Cumber1a	and		A116	egany	
		Age (In yrs. last birthday	/) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da	th Veer)	9. Birth	place (State or Foreign
	235-66-8832 ¹ ₺ м 2□ F	63 Yrs.	Worth's Days	Hours Will.	Sept.	25 , 1941	Wes	t Virginia
	Usual Residence of Decedent							
_	10a. State 10b. County	10c. City, Town or I	Location					10d. Inside City Limits
cto	WV Mineral	Keyse	er					1 ☐ Yes 2 No
)ire	10e. Street and Number		10f. Zip Code			10g. Citizen	of What Cou	ntry?
<u>e</u>	Rt. 6 Knobley Road		26726	6		1	USA	
ne.	11. Marital Status 12. Was Deceder Armed Forces	nt Ever in U.S. 13	. Was Decedent of His If Yes, specify Cuban	panic Origin? (Sp. Mexican, Puerto	ecify Yes or No		Race - Americal	
F	1 Never Married 2 Married 1 Yes 2 M		1□ Yes 2₺ No	Specify:	, , , , , , , , , , , , , , , , , , , ,		cify:	0.0.
d b	3 MWidowed 4 □ Divorced Year or Dates					J Ope	Wh	nite
Completed by Funeral Director	15. Decedent's Education (Specify only highest grade completed)	(Giv	edent's Usual Occupat e kind of work done du	uring most of work	king	16b. Kind o	Business/In	dustry
g.	Elementary/Secondary (0-12) College (1-40)	r 5+)	DO NOT use retired)					
ပိ	8	Lur	mber Stacke		- /5: 14:	Saw I		
Be	17. Father's Name (First, Middle, Last)			18. Mother's Nam	•		•	
은	George Philip Simpson				Virgin			
	19a. Informant's Name/Relationship (Type, Print)	19b. Mai	iling Address (Street ar			er, City or To	wn, State, Zip) Code)
	Marion Moorehead/Sister		D. Box 453	Keyser		6726		
	20a. Method of Disposition 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from Stat	20b. Place of Disp cemetery, cri	ematory or other place	Nov.	Date 8	20c. Locatio	on - City or To	own, State
	`4 ☐ Donation 5 ☐ Other (Specify)	Biser (Cemetery	200			ser, W	V .
	21. Signature of Funeral Service Licensee	7	22. Name and Address	of Facility Sm:	ith Fund	eral Ho	ome	
	1 Duan F Sul		85 S. Mai	in Stree	t Keyse	er, WV	2672	6
	23a. Part1. Enter the disease, or complications that cause shock, or heart failure. List only one cause on each	ed the death. Do not en	nter the mode of dying	, such as cardiac	or respiratory a	rrest,		Approximate Interval Between
	Immediate Cause (Final disease or condition	and Dem	entia					Onset and Death 3 4 cal 5
	resulting in death)	as a consequence of):	C77776C					Syews
	Commentally list and disease							
ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	as a consequence of):						
am	that initiated events							
Ä	resulting in death) Last Due to (or a	as a consequence of):						
Medical Examiner	d.							
Med	IF FEMALE:							
						001		
	23b. Was decedent pregnant		□Ectopic pregnancy				Date of delive	
	in the past 12 months? 1 Yes 2 No	2 Fetal death 3 at time of death 5	☐Ectopic pregnancy ☐ Other (specify)				Date of delive Month	ery Day Year
	in the past 12 months? 1 Yes 2 No 9 Unknown	2 Fetal death 3 at time of death 5	Other (specify)				Month	Day Year
	in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death	2 Fetal death 3 at time of death 5	Other (specify)	n in Part I.		obacco use c	Month ontribute to the	Day Year he cause of death?
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Be Completed by Physician	25. Was case referred to medical examiner? Second Was case referred to medical examiner? Constant Con	2 Fetal death 3 at time of death 5 but not resulting in the	Other (specify)	26. Place of Deal	24a. Was autop perfo	obacco use c	b. Were autoprior to codeath?	Day Year the cause of death? pably 4 Unknown posy findings available impletion of cause of 2 No
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State of Maryland / Department of Health and Mental Hygiene 2004 36843 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Day **Physician** 2004 Sister Monica Schanberger Nov. 8:11 A. /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Emmitsburg,

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year, Min. | 1. Onto 1. Day, Year, St. Vincent Care Center Frederick 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 1 □ M 2 🖾 F Director April 14,1912 Maryland 214-54-6811 Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28e-f show pernit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Importent: if item 27 is marked other than "netural", or items 23a or 28e-1 show any njury or other treumatic event, tre Medical Examination must be notified at once. Director 1X Yes 2 No Emmitsburg MD Frederick 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? U.S.A. 21727 335 South Seton Avenue Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race:- American Indian, Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 Specify: White 1 ☐ Yes 212 No Specify: 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Religious Community Elementary/Secondary (0-12) College (1-4or 5+) School Teacher Daughters of Charity College 5 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Loretta Ann Wehage Charles Louis Schanberger 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sister Camilla Harant 333 South Seton Avenue, Emmitsburg, MD 21727 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 11/15/2004 ST. JOSEPH'S P.H. EMMITSBURG, MD. 4 □ Donation 5 □ Other (Specify) 21. Signature Fune al Service Licensee 22. Name and Address of Facility SKILES FUNERAL HOME 210 W. MAIN ST., EMMITSBURG, 21727-0427 23a. Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiae shock for heart failure. List only one cause on each line. Immediate Cause (Final disease condition resulting in death) Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Completed by Physician/Medical Examiner The law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, use as the IF FÉMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy ŏ Day Year 5 Other (specify) been signed by the s should be detached to 1 ☐ Yes 2 K No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 2X No 3 Probably 4 Unknown 1 Tes 24b. Were autopsy findings available prior to completion of cause of death? page 2 autopsy performed? 1 ☐ Yes 2 ☐ No 1 Yes 2K No of Vital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Medical Certification: To Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 X No in by the funeral dir 3□ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Division 5 Pending 1 X Natural 1 ☐ Yes 2 ☐ No investigation М death. 2 Accident within 24 hours after death To the Funerel Director: completely filled in by the 6 Could not be determined 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1X Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medice Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29d. Date signed (Month, Day, Year) 29b. Signature and title of/cert 29c. License number 12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ALAN CARROLL, M.D., EMMITSBURG, MD. 21727 $310 \, s.$ SETON AVE. 31. Date filed (Month, Day, Year) 32, Registrar's Signature State Registrar NOV 1 9 2004

		•	For State Registrar	State of Marylan		artment of rtificate of		nd Mental Hy	/giene Reg. No.	004	36844
		7F:	1. Decedent's Name (First, Middle, Last)					2. Date of D Month	eath Day	Year	3. Time of Death
	Physicia /Medic	_	Thomas Leroy Ston	er				0ct 3			9:45 p ^M
1	Examin		4a. Fecility Name (If not institution, give s	treet and number)		4b. City, Town,	or Location of	Death	4c. C	ounty of Death	
*			8129 Harmony Road		la at hirthday	Dent		4 Hrs. 8. Date of B	idh	Caroli:	ne place (State or Foreign
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. I	Yrs.	Months Day		Min. (Month, E	^{9ay,} Year) 2 1947	Cou	intry)
Į.	Director		219-46-8249 Usuel Residence of Decedent					Aug I	2 1747	Wasii	ingcon, bo
	ylanc how		10a. State 10b. County	10c. City	, Town or L	ocation					10d. Inside City Limits 1 ☐ Yes 2X No
	B Mai	ctor	Maryland Caroli	ne Den	ton				1		
	or 28	Director	10e. Street and Number			10f. Zip Code				en of What Cou	untry?
	ath w		8129 Harmony Road	12. Was Decedent Ever in U.	6 12		629	in? (Specify Ves or N	USA 10- 14	1. Race - Amer	ican Indian.
	ltems Items	Funerai	11. Marital Status 1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 X Yes 2 □ No	3. 13.	If Yes, specify Cu	ban, Mexican,	in? (Specify Yes or N Puerto Rican, etc.)		Black, White	
36	hours after death with the Maryland tural; or Items 23e or 28e-1 show al Examinetr usal be nuffited at	by	3 ☐ Widowed 4 M Divorced	If Yes, Give Year or Dates: 1966-	70	1 ☐ Yes 2 🔀 N	o Specify:		S	Specify: Wh	ite
ğ	thin 72 hours after death with the Marylan e. an "natural", or Items 23e or 28e-1 show Madical Examinet roast be notified at	ted	15. Decedent's Edu (Specify only highest grade	cation	16a. Dece	dent's Usual Occ	upation ne during most	of working	16b. Kind	d of Business/I	ndustry
215	within 7 iene. than "r	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		kind of work dor DO NOT use reti		•		.1.4.6	
21	0 0 -	S	12		Polic	ce offic		's Name (First, Midd		chief	
Ind	V to D .	Be	17. Father's Name (First, Middle, Last) Harry Leroy Stone	er, Jr.				Arnold S		umaniej	
Maryland 21215-0036	s 1 and 2 should t f Health and Ment item 27 Is marked other traumatic	10	19a. Informant's Name/Relationship (Ty		19h Mail	ing Address (Stre	1	or Rural Route Num		Town, State, Z	ip Code)
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	Health tem 27 othar ti		20a. Method of Disposition	20b. P	lace of Disp	osition (Name of matory or other p		Date	-	ation - City or 1	Town, State
JO I	0 0		1 X Burial 2 ☐ Cremation 3 ☐ P '4 ☐ Donation 5 ☐ Other (Specify)					ov 4 2004	Hur1	ock, Ma	ryland
Baltimore,	- t = =		21. Signature of Funeral Service Licens	90	2	2. Name and Add	dress of Facility	fenbein F	uneral	Home.	PΑ
ä	Departing Department of the partment of the pa		1 CF	lugh	1	PO Box 1	60 Gree	ensboro, M	D 2163	39	
	A: 0		23a. Part1. Enter the disease, or compl shock, or heart failure. List only or	ications that caused the deat ne cause on each line.	h. Do not en	ter the mode of d	lying, such as c	ardiac or respiratory	arrest,		Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition	Small Of	el c	arcen	Me				Misury
1	/Medical Examiner	į,	resulting in death)	Due to (or as a conseq	uence of):						
	LXammer	_	sequentially list conditions,	Due to (or as a conseq	mence of):						
	ted nsit	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	500 10 (01 25 2 0011004							
	be executed ician and burial-transit	Examine	that initiated events resulting in death) Last	Due to (or as a conseq	uence of):					-	
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9	The law requires that the death certificate are has been signed by the attending physpage 2 should be detached for use as the	Aedi	IE ECIMIE.								
Вох	th cer tendir r use	an/N	23b. Was decedent pregnant	3c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta	death 3	□Ectopic pregna			23	3d. Date of deli Month	very Day Year
	e dea he att	Physician/Med	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	4☐Pregnant at time of o 9☐ Unknown	leath 5	Other (specify)			-		,
P.0	hat th d by i		Part II. Other significant conditions co	ntributing to death but not res	sulting in the	underlying cause	given in Part I.	23e. Di	d tobacco us	e contribute to	the cause of death?
ds,	aires that signed b	l by				, 3	•	1[J¥es 2□]No 3□Pr	obably 4 Unknown
Ö	w requir been si should	ete						24a. W	as an	24b. Were au	topsy findings available
Records,	The law ate has I page 2 s	Completed						ре	topsy normed? 2 12 No	prior to death?	completion of cause of 2 No
Vital	iician: Th certificate rector, pag	a	25. Was case referred to medical				26. Place	of Death (Check onl		, (2, 163	20110
>		O.B	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 Inpatient 2	ER/Outpatie	ent 3 DOA	Other: 4 Nur	rsing Home 5 Ale	sidence 6	Other (Spec	cify)
10	g Physier this	n; T	27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time Injury	of 28c. Ir	njury at Nork?	28d. Describ	e how injury	occurred	
Ö	Attanding F r death. octor: After by the funer	atic	2 Accident investigation				Yes 2 N				
Division of	r Att	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h building, etc. (Speci	ome, farm, s fy)	treet, factory, office	ce		(Street and Town, State)	Number or Hu	aral Route Number,
	To the Hospital or Attanding I within 24 hours after death. To tha Funaral Director: After completely filled in by the funer		200 Codifice 15 Codificing DL	sician: To the best of my know	nwladza do	th occurred at the	time data and	d place, and due to the	ne cause(s) e	and manner as	stated.
	Hosp 24 ho Fund Helly f	edical	29a. Certifier 1 Certifying Phy (Check only 2 Medical Exem	iner: On the basis of examina and manner stated.	ation and/or	nvestigation, in m	y opinion, deat	h occurred at the tim	e, date and	place, and due	to the cause(s)
	To the within 2 To the comple	Me	29b. Signature and title of certifier			29c. Lici	ense number		29d. Date	signed (Monti	h, Day, Year)
	0 42 m		> Murd	Drus		D:2	9887		/1/	3/04	
			30. Name and address of person who c			e, Print)				+ /	
_			David Smith, MD	29466 Pintai		ve, East	on, MD	21601			
	St Regist	ate	31. Date filed (Month, Day, Year)	32. Registrar's Sign		ast 1					
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DHMH 17 Rev 1/2001

ORIGINAL

			For State	State of M				d Mental Hyg	iene n) 4	36845
			Registrer 1. Decedent's Name (First, Middle	, (not)		Pertificate of	Death	2. Date of Dea	eg. No.	J 4	3. Time of Death
	Physicia	an			Ct	-1		Month	Day	Year	
	/Medic Examin		Joseph 4a. Fecility Name (If not institution	Willian n, give street and number		okes	or Location of D	November November	4c. Count	2004 y of Death	12:13 a ^M
	LXamiii	٠.	Calvert Memor:	ial Hospital		Prin	ce Frede	erick	Ca	lver	t
	Funeral		5. Social Security Number	6. Sex 7. A	ge (In yrs. last birtho	Months Dav		Min. (Month, Day	Year)	9. Birth	plece (State or Foreign
	Director		212-38-3920	XW ZUF	64 Yr	S. ,		May 13,	1940		h., D.C.
	land ow		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town o	r Location	· · · · · · · · · · · · · · · · · · ·				Od. Inside City Limits
	Many e-f sh	tor	MD Calv	ert		Lusby	7				1 ☐ Yes 2 XNo
	th the or 28e	Director	10e. Street and Number			10f. Zip Code		1	0g. Citizen of	What Cou	ntry?
	ath wi	ral	11309 Sitting			20657			USZ		
	er dei Items Der m	nue	11. Marital Status	12. Was Deceden Armed Forces	?	 Was Decedent of If Yes, specify Cu 	Hispanic Origin Iban, Mexican, P	? (Specify Yes or No- uerto Rican, etc.)		ce - Ameri ck, White,	
36	irs aft	by Funeral	1 ☐ Never Married 2 💢 Marr 3 ☐ Widowed 4 ☐ Divorced	ied 1 □ Yes 2 🕅 If Yes, Give Year or Dates	_	1 ☐ Yes 2🛣 N	o Specify:		Specia	^{fy:} wh	nite
Š	filed within 72 hours after death with the Maryland Hygiene. sther then "natural", or Items 23a or 28e-f show ent, the Medical Examinet must be notified at		15. Deceden	t's Education		ecedent's Usual Occ		funding	16b. Kind of B		
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Maryland 21215-0036	otal F	Be	17. Father's Name (First, Middle,	_			_	Name (First, Middle, Belle			
Ž	should nd Me mark matic	은	Paul 19a. Informant's Name/Relations	Stokes hip (Type, Print)	19b. N	failing Address (Stre	Anna et and Number o	or Rural Route Number		emp . State, Zid	Code)
	nd 2 salth ar 27 ls		Alice Christin	e Stokes, w				Trail, Lus		206	
Jre,	ges 1 and 2 should be filed within 72 hours after death with the Marylan it of Health and Mental Hygiene. If item 27 Is marked other then "natural", or Items 23a or 28e-1 show or other treumatic event, the Medical Examiner must be notified at		20a. Method of Disposition	2 TB	camatan/	isposition (Name of crematory or other p	lace)	Date	20c. Location	- City or To	own, State
<u><u>E</u></u>	Page ment ent: ti		1 XBurial 2 ☐ Cremation 14 ☐ Donation 5 ☐ Other (S		Ft. Li	ncoln Ceme	etery 11	-06-2004	Brentwo	ood,	MD
Baltimore,	permit. Pages 1 and 2 Department of Health a Importent: if item 27 Is any injury or other tre		21. Signature of Funeral Service	Licensee .		22. Name and Add Rausch Fu		ome, P.A.,	Owings	s, MD	20736
			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that cause only one cause on each	ed the death. Do not line.	enter the mode of d	ying, such as car	rdiac or respiratory arr	est,		Approximate Interval Between
	Enysician		Immediate Cause (Final disease or condition	My	acardial	Intero	tim				Onset and Death
	/Medical Examiner		resulting in death)	Due to (or a	s a consequence of)	:					
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	rted Insit	mine	any, leading to immediate cause. Enter Underlying Cause (Disease or injury		a so according to the cory						
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8760,	cate be executed physician and the burial-transit	dical		d							
9	ntifica ing ph	Med	IF FEMALE:								
Вох	death certific e attending p id for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months?		2 Fetal death	3 Ectopic pregnar	ісу		T .	ate of delive	ary Day Year
0		yslc	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown	at time of death	5 ☐ Other (specify)					
σ.		y Ph	Part II. Other significant condition	ons contributing to death	but not resulting in the	ne underlying cause (given in Part I.	23e. Did to	bacco use con	tribute to the	ne cause of death?
rds	requires leen sign hould be	ed by							s 2□No	3 🗆 Prob	ably 4 Unknown
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Ä	9 4 9	mo:						autops perfore	ned?	death?	mpletion of cause of 2□ No
/ita	ysicien: Th is certificate director, pag	Be	25. Was case referred to medica examiner?					Death (Check only or	-		
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on c	ding F h. After funera	lon:	27. Manner of Death 12. Natural 5 Pendir 2 Accident investi		jury 28b. Tin Pay Year) Inju	iry W	uryat 'ork? □Yes 2□No	28d. Describe h	ow injury occur	red	
Division	or Attending after death. Director: After in by the fune	Certification;	3 ☐ Suicide 6 ☐ Could	not be 28e. Place of Ir	niury - At home, farm	, street, factory, offic		28f. Location (Si	reet and Numb	ber or Rura	il Route Number.
<u>S</u>	after after I Dire	erti	4 Homicide	building, e	etc. (Specify)			City or Town	n, State)		
	To the Hospitel or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	edical C	29a. Certifier Check only one) Certifyir 2 Medical	ng Physician: To the bes Examiner: On the basis and manners	of examination and/	death occurred at the or investigation, in my	time, date and p	place, and due to the coccurred at the time, d	ause(s) and ma ate and place,	anner as s and due to	tated. the cause(s)
	To the Within To the	Me	29b. Signature and title of certifie			29c. Lice	nse number		9d. Date signe		
			1	Whom		0	17610	f	しているか	2	3,2004
	10		30. Name and address of person David Tardio				310 0	r Fradari	ole M	20.0	70
	Sta Registi		31. Date filed (Month, Day, Year)	0 4 2004	tres Signature	* Sports	- 210, P	r. r.egeri	CK, MD	206	/0
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		4		State of Marylan	nd / Depa	rtment of H	ealth and N			36846
			Registrar 1. Decedent's Name (First, Middle, Last)		Cei	illicate of L	Jealli	2. Date of Deat	eg. No.	3. Time of Death
	Physicia	เก						Month October	Day Yee	
	/Medic		David Raymond Taxo 4a. Fecility Name (If not institution, give stre			4b. City. Town, or	Location of Death	occoper	4c. County of De	9:50 P M
	Examin	er	Prince George's Hos			Cheverly			Prince G	_
	Euporol		5 Social Security Number 6. Sex	7. Age (in vrs.	last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth		irthplace (State or Foreign Country)
	Funeral Director		277-32-3114 ¥□M	2□F 70	Yrs.	Months Days	Hours Min.	June 10	, 1934 Oh:	Lo
		- 1-	Usual Residence of Decedent							
	rylan		10a. State 10b. County	10c. Cit	ty, Town or Lo	cation				10d. Inside City Limits X□Yes 2□No
	e Ma	9	Maryland Montgomery	Gai	thersb					
	or 2		10e. Street and Number			10f. Zip Code		1	log. Citizen of What	Country?
	death with the Maryland ms 23a or 28a-f show I must be notified at	Funeral Director	7907 Baden Lock Way			20879	. 0 0 /0-		USA	naisea ladina
	er de	nue	TI. Wanta States	Was Decedent Ever in U Armed Forces?	. 1	Was Decedent of Hi f Yes, specify Cuba	ispanic Origin? (Sp n, Mexican, Puerto	Rican, etc.)	Black, W	nerican Indian, nite, etc.
20	hours after tural', or ite	by F	1 Never Married 2 Married 3 Widowed 4 Divorced	1 XYes 2 No 195 If Yes, Give Year or Dates: 195		1□Yes 2\\X\\No	Specify:		Specify:	White
3	hou	edit	15. Decedent's Educati		16a Deced	ient's Usual Occupa			16b. Kind of Busines	ss/Industry
Ċ	within 72 ene. than "nai	plet	(Specify only highest grade of Elementary/Secondary (0-12)	College (1-4or 5+)	(Give	kind of work done a DO NOT use retired	furing most of worl)	king		
9500-61212	r the	Completed		Yrs.	0cea	nographer			U.S. Gov	ernment
	be filed within 72 hours after death with the Marylan tal Hygiene. Ital Hygiene. Ital Medical Examination to must be multified at event, the Medical Examination to multiple at	Be C	17. Father's Name (First, Middle, Last)				18. Mother's Nam	e (First, Middle, i	Maiden Sumame)	
<u>a</u>	wid b Wents rrked	2	Andrew Taxon				Emma Ma	ger		
Maryland	2 sho and I		19a. Informant's Name/Relationship (Type,			•			r, City or Town, State	
Σ.	permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If I ten 27 is marked oth any injury or other traumatic event once.		Kim Fiorentino- Gua		4		le Pike	1	kville, M	
Baltımore,	of H of H if ite		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Rem		cemetery, crer	sition (Name of natory or other plac	e)	Date	20c. Location - City	or Town, State
Ē	Pag tment tant: jury		*4 ☐Donation 5 ☐ Other (Specify)	U		emetery				sville, OH
Za Za	Permit Depar Inpor Iny in		21. Signature of Funeral Service Licensee	17.0					ldi Funera	
			23a. Part 1. Enter the disease, or complicat	tions that says and the day			<u>-</u>			ing, MD 20904
5		Ì	shock, or heart failure. List only one	cause on each line.	III. DO NOL GIII	er the mode of dyin	y, such as cardiac	or respiratory arr	6 31,	Interval Between Onset and Death
Н	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	Sepsis						6 Weeks
п	Examiner			Due to (or as a consec Acute R		ailuro				6 Weeks
10		er	Sequentially list conditions, if any, reading to immediate	Diua to (or as a consec		411416				O WEEKS
	uted	Examiner	it any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events							
o Î	an an irial-tr	EX	resulting in death) Last	Due to (or as a consec	quence of):					I
8760,	The law requires that the death certificate be executed to has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	dical	d							
9	eath certific attending pl	Med	IF FEMALE:	w C						
Вох	ath ce	lan/	23b. Was decedent pregnant in the past 12 months?	If yes, outcome of pregn 1□Live birth 2□Feta	al death 3□	Ectopic pregnancy			23d. Date of d	lelivery Day Year
0	by the a	Physiclan/Me	1 Yes 2 No	4☐Pregnant at time of o	death 5L	Other (specify)				
مز	that the		Part II. Other significant conditions contril	buting to death but not re-	sulting in the u	nderlying cause give	en in Part I.	23e. Did to	bacco use contribute	to the cause of death?
ds,	signed b	d by	Respiratory Failur	e				1 🗆 Y	es 2 No 3	Probably 4 XUnknown
Ö	w requir been si should I	ete	Diabetes Mellitus					24a. Was a	an 24h Were	autopsy findings available
Records,	has ge 2	Completed	Diabetes Mellitus					autops	sy prior t med? death	o completion of cause of ?
a			Pulmonary Edema 25. Was case referred to medical				26 Place of Dea	1 ☐ Yes th (Check only or	A	es 2 No
Division of Vital	Attending Physician: sr death. ector: After this certifica by the funeral director.	o Be	examiner?	spital:	ER/Outpatier	nt 3 DOA Othe	or		ence 6 Other (S	pecify)
ō	ding Phys th. After this funeral dir	\vdash	27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time o		y at		ow injury occurred	,,
<u>io</u>	ittending death. ctor: Aft y the fun	atlo	1 Natural 5 Pending 2 Accident investigation	(Month, Day 1 ear)	Inquiry		Yes 2 □No			
vis	or Attendate death Director:	tifle	3 Suicide 6 Could not be determined	28e. Place of Injury - At h		eet, factory, office		28f. Location (S City or Town	treet and Number or n, State)	Rural Route Number,
ō	ital or A rs after al Dire	Certification;								
	Hospi 4 hou Funer	cal	(Check only2 _ Medical Examine)	ian: To the best of my kn r: On the basis of examin						
	To the Hospital or At within 24 hours after d To the Funeral Direct completely filled in by	Medical	29b. Signature and title of certifier	and manner stated.		29c. Licensi	e number		29d. Date signed (Mo	nth. Dav. Year)
	To Too		250. Signatura and title of Certified	Musty			6273		4/1/0	4
	150		7/ 30000	11/	- 02-1 7				1 1	r
	A)	30. Name and address of person who com				*1v MD	20785		
	Sta	te	Revathy Murthy, M. 31. Date filed (Month, Day, Year)	32. Registrar's Sign				20/03		
	310	ne ar	NOV 0 4 2004	Ceneral	29	doark				

	-	For State Registrar	State of Marylar	nd / Depa	artme		Ith and N	Mental Hygi	ene 200 L	36847
Physicia /Medica	1		CZAK					2. Date of Death Month NOVEMB	Day Year ER 14 20	04 10:15a
Examine Funeral Director	J	4a. Facility Name (If not institution, give s Chester River H 5. Social Security Number 6. Sex 222-20-9712			Cl			8. Date of Birth (Month, Day, Aug 20	Kent Year) 9. Bi	nthplace (State or Foreign ountry)
ō	lor	Usual Residence of Decedent 10a. State	10c. Ci	ty, Town or Lo		1		1149 20	233., 36	10d. Inside City Limits 1 ☐ Yes 2 ▼No
death with the Maryland ms 23a or 28a-1 show final to notified a	Funeral Director	10e. Street and Number 207 Longfellow	Dr.			ip Code			g. Citizen of What C	ountry?
urs after	2	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:			edent of Hispan ecrfy Cuban, Me		pecify Yes or No- Rican, etc.)	14. Race - Am Black, Whi Specify:	
within 72 ho	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0·12)	ation completed) College (1-4or 5+)	(Give	kind of w DO NOT	ual Occupation ork done during use retired)		king	6b. Kind of Business	Mindustry L Company
be file dothe event.	10 Be C	12 17. Father's Name (First, Middle, Last) William Callaha	an	I acki	.11.9	18.	Mother's Nam	e (First, Middle, M Barrow		Company
C = 01 L		19a. Informant's Name/Relationship (Type Sigmund Tomcza)	(husband	1) 207	Lo	ngfell	ow Dr	. Chest		MD. 21620
permit. Pages 1 a Department of Hea Important: if item Iny injury or othe		20a. Method of Disposition 1 ⊠ Burial 2 □ Cremation 3 □ Re 4 □ Donation 5 □ Other (Specify)	emoval from State C		matory or On C	emeter	y 11/	17/04	Crumpto:	n, MD.
permil Depar Impo		21. Signature of Funeral Service License 21a. Pant. Enter the disease, or complice	М00	510 1	18 M	est Cr	coss S	St. Gale	ena, MD.	L. Schaec 21635
Physician /Medical]	Immediate Cause (Final disease or condition resulting in death)	SEPSIS Due to (or as a consec	quence of):				or respiratory arre	st,	Interval Between Onset and Death Z 4 Luss
te be ysicie	Ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consecutive to (or a) consecutive to (or a) consecutive to (or a) consecutive to (or a) consecutive to (or a) consecutive to (or a) consecutive to (or a) consecutive to (or a) consecutive to (or a) consecutive to (or a) consecutive to (or a) consecutive to (or a) consecutive to (or a) consecutive to (or a) consecutive to (or a) consecutive to (or a) consecutive to (or a) consecutive to (or a) co	quence of):		OPEN NCRE		CANC	ER	Zyears
The law requires that the death certifical that been signed by the attending phoage 2 should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	3c. ff yes, outcome of pregn 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of o 9 ☐ Unknown	al death 3	⊒Ectopic ⊒ Other (pregnancy specify)			23d. Date of de Month	ofivery Day Year
quires that the de	2	Part II. Other significant conditions con	tributing to death but not res	sulting in the u	inderlying	cause given in	Part I.		_ _	o the cause of death?
	Completed							24a. Was an autopsy perform 1 □ Yes 2	prior to	utopsy findings available completion of cause of
ysicien: The is certificate hi director, page	o Re	25. Was case referred to medical examiner? 1 Yes 2 No	ospitaf: Inpatient 2	ER/Outpatier	nt 3 🗆 🗈	Other		th <i>(Check only one</i>	nce 5 Other (Spe	ecify)
Ing Ph Mer th Inneral	ation; I	27. Manner of Death Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time o Injury		28c. Injury at Work? 1 ☐ Yes		28d. Describe hor		,
To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h building, etc. (Speci	(fy)				City or Town,		
To the Hospitel or within 24 hours after To the Funeral Dir completely filled in	Medical	29a. Certifier Ameritying Physical Check only one) Medical Exemin	ician: To the best of my known: On the basis of examination and manner stated.	owledge, deat ation and/or in	h occurre vestigation	d at the time, da in, in my opinior	ate and place, n, death occur	and due to the ca red at the time, da	use(s) and manner a te and place, and du	s stated. e to the cause(s)
To the within To the comple	Me	29b. Signature any title of certifier	na mo		2	9c. License nun	0415	87	d. Date signed (Mon	yn, Day, Year) 2004
3		11010111111	ble mp 1	22 51	Print)	Rd.	Che	stentu	un, MI	721620
Stat Registra		31. Date filed (Month Pay Year) 9 20	32. Registrar's Sign	ature	1	bords				

DHMH 17 Rev 1/2001

			For	State of Maryland	d / Depa	rtment of Health ar	nd Mer	ital Hygien	e2nnl	36848
		_1	= State Registrar		Cer	tificate of Death		Reg. N	o	3. Time of Death
	Physicia /Medic	in al	1. Decedent's Name (First, Middle, Last) SUSSIE ELI	ZABETH T	DRE	BERT		Month - O	2 - 200	4 1055 PM
	Examin	er	4a. Fecility Name (If not institution, give s	RSING HOD	NE	4b. City, Town, or Location of DENTON			c. County of Death	INE
(3) (6)	Funeral Director		5. Social Security Number 6. Security Number 15	7. Age (In yrs. Ia	ast birthday) Yrs.	Months Days Hours	Min. 8.	Date of Birth (Month, Day, Yea)-23-1	9. Birti	nplace (State or Foreign untry)
	iryland show		Usuel Residence of Decedent 10a. State 10b. County	10c. City,	, Town or Lo	cation				10d. Inside City Limits
	death with the Maryland rms 23a or 28a-f show rmust be notified at	lrecto	10e. Street and Number	INC IFE	DEKI	10f. Zip Code		10g. C	Citizen of What Co	
	death wi	Funeral Director	303 VESPER	12. Was Decedent Ever in U.S Armed Forces?	S. 13. \	Vas Decedent of Hispanic Origin f Yes, specify Cuban, Mexican,	in? (Specify Puerto Ric	Yes or No-	14. Race - Ame Black, White	
036	ours after al', or ite	þ	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		Yes 2 No Specity:			Specify: W	HITE
215-0036	should be filed within 72 hours after death with the Marylan nd Mental Hygiene. marked other then "natural", or Items 23a or 28a-f show imatic event, the Medical Exama sermust be notified at	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0·12)		(Give	lent's Usual Occupation kind of work done during most of DO NOT use retired)	of working		Kind of Business/	40
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aryland	should be filed with and Mental Hygiene. I marked other ther umatic event, The	To Be	MARTIN ROLAN	D MORGAN		505	SIE	D. WA	IRD	
≥	nd 2 :: Ilth ai 27 Is r trau	1	19a. Informant's Name/Relationship (T)	DAUGHTER	24713	ng Address (Street and Number	ICH I	PRIVE D	I, NOTUE	no 21632
altimore,			20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	Removal from State	lace of Dispo emetery, crer	sition (Name of natory or other place)	Date	04 FE	Location - City or DERAL	Town, State SBURGMD
Balti	permit. Pages Department of Important: If I any injury or once.		21. Signature of Fungral Service Licens	88	ير ک	Name and Address of Eacility	IERAL STOI	HOME	RALSBU	RG.MO211632
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	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. Sep 5 1 Due to (or as a consequ	S nence of):					Onset and Death
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	ecuted and transit	Examiner	Cause (Disease or injury	c. Due to (or as a consequ						
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	law requires that the as been signed by th 2 should be detache	ρ	Part II. Other significant conditions co	intributing to death but not resu	ulting in the u	nderlying cause given in Part I.		23e. Did tobacc 1 ☐ Yes	- /	the cause of death?
Vital Records,	e tar has	Completed						24a. Was an autopsy performed	prior to death?	utopsy findings available completion of cause of
/ita	ysician: Th is certificate director, pag	Be C	25. Was case referred to medical examiner?	Hospital:		Other		Check only one)		
of/	g 8	- 1º	1 Yes 2 No 27. Manner of De th	1 Inpatient 2	ER/Outpatie	T 3L DOA 4LE NUI		 Residence Describe how in 	6 ☐Other (Spe jury occurred	cify)
sion	ending sath. or: After he fune	ation	1 Natural 5 Pending investigation		Injury	Work? M 1 ☐ Yes 2 ☐ N				
Division	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At he building, etc. (Specify	ome, farm, st y)	reet, factory, office	281	. Location (Street City or Town, St	and Number or Ri ate)	ural Route Number,
	ne Hospi n 24 hour ne Funer sletely fills	edical	29a. Certifier (Check only one) Certifying Physics 2 Medical Example 1	ysician: To the best of my kno niner: On the basis of examinal and manner stated.	wledge, dea ition and/or in	h occurred at the time, date and vestigation, in my opinion, deat	d place, and h occurred	at the time, date a	and place, and due	e to the cause(s)
)	To the within To the comp	Me	29b. Signature and title of certifier	Siles	14	29c. License number	76		Date signed (Mont	
			30. Name and address of person who	completed cause of death (Item	n 23a) (Type	arket St	D	oton	, 46	221629
	St Regist	ate rar	31. Date filed (Month, Day, Year)	32. Registrar's Signa	ature	A)			•	
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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. NoZ U U 4 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 28,2004 **Physician** Roy Wilburn, Jr. October 1:00p M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** 14951 Hardship Farm Place Waldorf Charles | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Months | Days | Hours | Min. | March | 24, 1922 | Indiana 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral ™** M 2□F 82 317-12-3829 Director Usual Residence of Decedent 10c. City, Town or Location 10b. County 10a. State 10d. Inside City Limits or than "naturel", or Items 23a or 28a-f ehover the Medical Examiner must be notified at 1 ☐ Yes 2 XNo Maryland Charles Waldorf Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 14951 Hardship Farm Place 20601 U.S.A. by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Never Married 2 ☐ Married $\langle \mathcal{L} / I/\mathcal{D} \mathcal{U} R / \mathcal{L} \rangle$ Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White 3 Widowed 4 □ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Unknown other traumatic event. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Roy Wilburn Belle Armstrong 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20601 14871 Grace Keller Dr., Glenn A. Myers Executor Waldorf, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) Nov. 3, 2004 tfmore, Importent: If item any injury or other 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Cheltenham, Maryland Maryland Veterans Cemetery 22. Name and Address of Facility
Williams Funeral Home, 21. Signature of Funeral Service Licenses P.A. 20640 M00668 4270 Hawthorne Rd., Indian Head, Md. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical onsequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of attending physician and for use as the burial-transit Examin Due to (or as a consequence of): Box 68760, The law requires that the death certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4□Pregnant at time of death 5 Other (specify) P.O. I 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 2010 3 ☐ Probably 4 ☐ Unknown certificate has been si rector, page 2 should Completed •24b. Were autopsy findings available prior to completion of cause of death?

1 \(\sum \text{Yes} \) 2 \(\sum \text{No} \) 24a. Was an Yes Be 25. Was case referred to medical director 26. Place of Death (Check only one) examiner2 Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 esidence 6 Other (Specify) 2 No 1 🗆 Yeş Certification: To this Natural er of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Hospital or Attending 5 Pending investigation after death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide n 24 hours after de ne Funeral Directo detely filled in by the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 🗹 Certifying Physicien: To the best of n 🖟 owledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely (Check only one) within 2 To the the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year, D - 3717430. Name a address of person who completed cause of death (Item 23a) (Type, Print) 371 C. Chon, MD 7C Post Office Road Waldorf, Maryland 20602

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State

Registrar

31. Date filed (Month, Day, Year)

NOV 1 9 2004

ORIGINAL

32. Regis

		1 - For Stete Registrar 1. Decedent's Name (First, Middle, Last)	State of Marylan		artment of F		2. Date of De	Reg. No.2 () () [
Physic /Med Exam	ical	Audrey Arle			4b. City, Town, o	r Location of Death	MONEMB	Day Yee FR 15, 2	004 6:50 M
Funera Director		CITIZENS VURS 5. Social Security Number 6. Sex	/NG HOME 7. Age (In yrs. 75	last birthday) Yrs.	HARVE 1 If Under 1 Year Months Days	DE GRACI If Under 24 Hrs. Hours Min.	8. Date of Bird (Month, Da May 2	HAR	FOR D Birthplace (State or Foreign Country) Virgini
e Maryland 8a-f show	Director	MD Harfor		y,TownorLo Havre	de Gra	ce			10d. Inside City Limits 1 ☐ Yes 2 💆 No
ath with the 23a or 2	ral Dire	10e. Street and Number 4029 Gravel Hi	ll Road		10f. Zip Code 21	078		10g. Citizen of What U.S.A.	
Naryland 21215-0036 2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or flems 23a or 28a-f show reumatic event, the Medical Everniner must be redified at	by Funeral	11. Marital Status 12 1 □ Never Married 2 □ Married 3 □ Widowed 4 ▼ Divorced	 Was Decedent Ever in U. Amed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 		Vas Decedent of H Yes, specify Cuba	lispanic Origin? (Sp an, Mexican, Puerto Specify:	pecify Yes or No Rican, etc.)	- 14. Race - Ai Black, W Specitwih:	•
21215-0036 bd within 72 hours attgenen. or than "natural", or or than "matural", or or than "matural", or or than "matural" or or than "matural".	Completed	15. Decedent's Educi (Specify only highest grade Elementary/Secondary (0-12)	completed) College (1-4or 5+)			ation during most of work d)	king	16b. Kind of Busines	
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~ 5€21	-	19a. Informant's Name/Relationship (Type Robert S. Wheat	e, <i>Print)</i>			and Number or Rui	al Route Numbe	er, City or Town, State	
imo Page nent c		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Re 1 □ Donation 5 □ Other (Specify)	HIOVAI HOIH STATE	ford Me	sition (Name of natory or other placem. Gdns	11/1		20c. Location - City Aberdeen,	or Town, State
Balt. permit. Departr Imports any inje		21. Signature of Fineral Service Licenses	3. 200-	Z 22	Name and Addre Farring—(Aberdeen	ss of Facility Cargo Fund Maryland	eral Hon	ne, P.A. 1-3399	
System (1997) Sy	licai Examiner	23a. Part1. Enter the disease, or complic shock, or heart failure. List only one immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last d.	Due to (or as a consequ	uence of): ry cut to uence of):	Inforct		or respiratory ar	rest,	Approximate interval Between Onset and Death in me disate
P.O. Box 68 that the death certifical ed by the attending phi detached for use as it	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	c. If yes, outcome of pregna 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of de 9 □ Unknown	death 3	Ectopic pregnancy Other (specify)			23d. Date of d Month	lelivery Day Year
ds sign	ed by Ph	Part II. Other significent conditions control	ributing to death but not resu Callure	Ilting in the un	derlying cause give	en in Part I.	1,75		to the cause of death? Probably 4 □Unknown
AUDI II Recor The law requate has been page 2 should	Completed	Nontasilia Degen	reant Diabete	3 Melli	tis		24a. Was a autop perfor	med? death	
Sion of Vital F sion of Vital F seath. The seath. The corrections the funeral director, pag.	To Be	1 165 212 140	spital: 1 Inpatient 2			Wursing Ho			
Sion stending Beath.	Certification;	27. Manner of Death 1 Netural 5 Pending investigation 3 Suicide 6 Could not be determined	28a. Date of Injury (Month, Day Year) 28e. Place of Injury - At ho building, etc. (Specify	28b. Time of Injury		/ at ⟨? Yes 2 □ No		ow injury occurred itreet and Number or In, State)	Rural Route Number,
Hospital Hospital Hours S Funeral	Medical Cer	(Check only 2 Medical Exemine	cian: To the best of my knower: On the basis of examinat	wledge, death	occurred at the timestigation, in my op	ne, date and place, pinion, death occur	and due to the c	cause(s) and manner a	as stated. ue to the cause(s)
To the I within 2 To the I complete	Med	29b. Signature and title of certifier	Shulle w		29c. License	number 28050	2	29d. Date signed (Mor	
6		30. Name and address of person who com Prashant Shukla	1, MP 155	Parto	Ct. # 400	Aberde	en mo	21001	
St Regist	ate rar	31. Date filed (Month, Day, Year) NOV 1 9 2004	32. Registrar's Signat	Ure A	pach!			•	•

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Year **Physician** 12:25 A^M October 31, 2004 Jin Juan Wang /Medical 4a. Facility Name (If not institution, give street and number) 4h. City. Town, or Location of Death 4c. County of Death **Examiner** Shady Grove Adventist Hospital Rockville Montgomery If Under 1 Year | If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months 1 □ M 2 🕅 F Days Hours Director 543-29-4256 57 02/27/1947 China Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d Inside City Limits 10a State 10h Counts 28a-f ehow other treumetic event, the Medical Examiner must be notified at 1 X Yes 2 ☐ No Director Montgomery Gaithersburg 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Numbe with 9 Items 23a 431 Muddy Branch Road, Apt. 202 20878 China Completed by Funeral Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Yes No If Yes, Give Year or Dates: 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 ō 1 ☐ Yes 2 No Specify 3 Widowed 4 Divorced Asian "naturel", 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Accountant Accounting 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ie marked of Xi Xian Ye Yao Cheng Wang 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20878 19a. Informant's Name/Relationship (Type, Print) Department of Health a Importent: If item 27 is any injury or other tree once. 431 Muddy Branch Road, Apt. 202, Gaithersburg, MD Michael H. Wang, Son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 11/02/2004 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Baltimore Crematory 21 Signature of Fundal Service Licensee 22. Name and Address of Facility Simple Tribute 1040 Rockville Pike, Rockville, Maryland 20852 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Cardiac Arrest Minutes disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner End stare Renal Disease 2 Years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed use as the burial-transi Due to (or as a consequence of) Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Year Month Day 4☐Pregnant at time of death 5 ☐ Other (specify) P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ pe 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy perfor 1 🗌 Yes 1 Yes Hospital or Attending Physician: director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 X No P 1 Inpatient 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred Certification: 5 Pending investigation 1 XNatural 1 🗀 Yes 2 🗀 No death 2 Accident after death Director: 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 | Homicide 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 0 0005484 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Charles, 9901 Medical Center Drive, Rockville, Maryland 20850 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 0 4 2004 NOV Registrar

			State of Mar	yland / Depa <i>Cer</i>	rtment of l tificate of	Health and <i>Death</i>		giene () () 4	36852
	DI COM	1. Decedent's Name (First, Middle, Le.	st)				2. Date of De Month	ath Day	Year	3. Time of Death
	Physician /Medical	Roger Williams					Octobe			12:00 PM
	Examiner	4a Facility Name (If not institution, giv	e street end number)			4b. City, Town, o	r Location of Deat			
		HCR Manor Care				Chevy Cl		Montg	omery	
	Funeral	Social Security Number 6. S	ex 7. Age (☑ M 2□ F	In yrs. lest birthdey)	If Under 1 Year Months Days			th ey, Year)	9. Birthpl	ace (State or Foreign try)
	Director	297-03-5283	20 M 20 F	86 Yrs.			02/13/	1918	Geor	
	and *	Usual Residence of Decedent 10a. State 10b. County	1	Oc. City, Town or Loc	ation				10	Od. Inside City Limits
	r 28a-f show northed at	MD Montgome	rv	Chevy Cha	C A					1 □ Yes 2 X No
	the Mt	10e. Street and Number	19	onevy ona	10f. Zip Code			10g. Citizen of	What Count	trv?
	fler death with the Mai r Items 23a or 28a-f s wher must be notified Funeral Director	8700 Jones Mill R	oad		20815			U.S.A.		
	rs 2;	11. Marital Status		er in U,S. 13. V	4	Hispenic Origin?	(Specify Yes or No erto Rican, etc.)		ce - America	an Indian,
0	or items	1 ☐ Never Married 2 ☐ Married	12. Was Decedent Even Armed Forces? 1 ☑ Yes 2 ☐ No	If			erto Rican, etc.)		ck, White, e	
05	ors a	3 X Widowed 4 □ Divorced	If Yes, Give Year or Dates: W	1 1	☐ Yes 2🎇 No	Specify:		Specify	v: Bla	ck
21215-0020	led within 72 hours after death with the Maryland ygiane. Nor than "natural", or items 23s or 28s-f show nt, the Medical Examiner must be norified at Completed by Funeral Director	15. Decedent's Ed (Specify only highest gre	lucation	16a. Deced	ent's Usual Occu	pation	norkina	16b. Kind of B	usiness/Ind	ustry
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21	Hygian the the sent, the	unk.	unk.	Tailo	r			Garme		
pu	d offi	17. Father's Name (First, Middle, Lest)					ame (First, Middle,	Maiden Surnan	ne)	
Уlа	should and market market urmatic	Green Williams				Ida (ı			,	
Mar	2 sh land ls m	19a. Informant's Name/Relationship (• • • • • • • • • • • • • • • • • • • •				Purel Route Numb	-		
e)	1 end Health mm 27 ther to	LaVerne Brown, Ni		20b. Place of Dispos		Drive,	Coungs tow	20c. Location -		
Baltimore, Maryland	permit. Pages 1 end 2 should be filed within 72 hours Department of Health and Mental Hygiane. Important: If Item 27 is marked other than "natural; any injury or other traumatic event, the Medical Exugace.	1 ☐ Burial 2 【XI Cremation 3 ☐	Removal from State	cemetery, crem	atory or other pla					
Ħ	rtant:	4 Donation 5 Other (Specify	, , , , , , , , , , , , , , , , , , ,		11/05/04		wood,	Maryland		
Ba	permit Depart Import any in	21. Signature of Funeral Service Licen	1 / 7		Name and Addre		Simple T			
		Janly Nes	ankley				ke, Rockv	-	-	
		23a. Part . Enter the dis-ase, or comp shock, or heert failule. List only	one cause on each line.	death. Do not ente	r the mode of dyl	ng, such as cardi	ac or respiratory a	rrest,		Approximate Interval Between Onset and Death
	Physician /Medical	Immediate Cause (Final		5	a					
	Examiner	disease or condition resulting in death)	a	e to (or as a consequ	onice.				+	- 1
	ė d			^					i	
	physician end s the burial-transit	Sequentially list conditions		e to (or as a consequ		uentic	1			
oʻ	an en rial-tr	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury								,
68760,	icate be axecuted physician end s the burial-transit edical Examir	that initiated events resulting in death) Last	c	e to (or as a consequ	ence of):				-	
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Вох	aath certifi attending d for use as ician/Me		0.				-			
	e daz the a hed f	Part II. Other significant conditions co	ontributing to death but r	ot resulting in the un	derlying cause gi	ven in Part I.	23b. Did 1	lobacco usa co	ntributa to	tha causa of death?
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of Vital Records,	w requires that been signed to should be deta sieted by P						04-11/		24h Was	o autopsy findings
Ö	requiriponic						perfo	an autopsy rmed?	avai	re autopsy findings ilable prior to apletion of cause
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Vit	certificata ractor, pag	25. Was case referred to medical examiner?	Hospital:		Oth		eath (Check only o			
of	physic this cal dire	1 Yes 2 No	1 L Inpatient		3LI DUA	44 Nursing	Home 5 Resid			
ב	Attending Physician: or death. ector: After this certific. by the funeral director, iffication: To Be (27. Menner of Death 1 □ Natural 5 □ Pending	28a. Date of Injury (Month, Day Y	ear) 28b. Time of Injury	28c. Inju Wo M 1	ryat rk?]Yes 2 ∐No	280. Describe i	now injury occuri	rea	
isi	death death ttor: tha	2 Accident investigation 3 Suicide 6 Could not be		- At home, farm, stre		7 163 2 110	28f Location /	Street and Numb	er or Bural	Route Number
Division	or A after Direction by	4 ☐ Homicide determined	building, etc. (Specify)	et, factory, office		City or Tow	vn, State)	or or norar	House Wallider,
	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificata he completaly filled in by tha funeral director, page Medical Certification: To Be Com	29a. Certifier Certifying Phy	ysician: To the best of m	ny knowledge, death	occurred at the ti	me, date and plan	e, and due to the	cause(s) end ma	inner as sta	ited.
	Fui Hetaly		ilner: On the basis of ex and manner stated	amination and/or inve	estigation, in my	opinion, death occ	curred at the time,	date and place,	and due to t	the cause(s)
	withir To the comp	29b. Signature and title of certifier	\		29c. Licens	se number		29d. Date signed	d (Month, D	ay, Year)
	/	10			100	54566		11/2/0	4.	
	5)	30. Name end eddress of person who o	completed cause of deat	h (Item 23a) (Type, P					·	
	1x	Sui tera Bhogavil				. Scein 2	30 Tag	250 W 1	1021	286
2.0	State	31. Date filed (Month, Day, Year)	32. Registrar's	Signature			1	- for		
	Registrar	NOV 0 4 200	14 Lenar	To the same of the	porks	-				

DHMH 16 Rav 6/95

		ı	State of Maryland / Dep	eartment of Health and Me	ntal Hygie	ne 2001	2000
			Registrar 1. Decedent's Name (First, Middle, Last)		Reg. Date of Death	No.C U U 4	36853 3. Time of Death
I	Physici		ANNE WISHER	No	ovember	4, 2004	2:00 A M
>	/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	
			7320 Radcliffe Drive	College Park		Prince Ge	•
	Funeral		5. Social Security Number 6. Sex 1 M 2 13-44-6151 6. Sex Yrs. 89 Yrs.	Months Days Hours Min.	Date of Birth (Month, Day, Ye	1914 Penn	place (State or Foreign
	Director		213-44-6151 S9 Yrs. Usual Residence of Decedent		04. 23,	1314 1 61111	Sylvania
	nyland ihow		10a. State 10b. County 10c. City, Town or L	ocation			10d. Inside City Limits
	8a-fs	cto	<u> </u>	ege Park			XXYes 2 □ No
	with the	Dire	10e. Street and Number 7320 Radcliffe Drive	10f. Zip Code 20740	10g.	Citizen of What Cou	intry?
	ns 23	Funeral Director		Was Decedent of Hispanic Origin? (Specifit Yes, specify Cuban, Mexican, Puerto Ric	y Yes or No-	14. Race - Amer	
9	or ite	Fur	Armed Forces? 1 Never Married 2 Married 1 Yes 2 Married 1 Yes, Sive	If Yes, specify Cuban, Mexican, Puerto Ric	can, etc.)	Black, White	
003	72 hours after death with the Maryland natural', or items 23a or 28a-f show disal Examinat must be ricitified at	d by	3 XWidowed 4 □ Divorced Year or Dates:			Specify:	White
15-	n 72 h	olete	(Specify only highest grade completed) (Giv	edent's Usual Occupation e kind of work done during most of working DO NOT use retired)	166	. Kind of Business/li	ndustry
212	d within giene. r than	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	Teacher		Educa	tion
nd	be filled tal Hygid of other event, I	Be C	17. Father's Name (First, Middle, Last)	18. Mother's Name (F		den Surname)	
ylaı	should band Ment marked umatic e	To	(unavailable) McKinley	Sarah Mo			
Maryland 21215-0036	d 2 sh h and 7 ts m traum	10. 1	7 . 7	ling Address (Street and Number or Rural F Panda Court, Waldor			p Code)
	1 and Healt tem 2	n	20a. Method of Disposition 20b. Place of Disp	position (Name of paratory or other place)		Location - City or T	own, State
mol	Pages nent of I int: If it		1 □ Burial 2 ☑ Cremation 3 □ Removal from State '4 □ Donation 5 □ Other (Specify)	rematory 11-5-	04 Wa	ldorf, MD	20601
Baltimore,	perrit. Pages 1 and 2 should be filled within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importants if item 27 is marked other than "natural; or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinat must be notified at ances.			22. Name and Address of Facility			
8	88188		Mark M. Brokerm	22. Name and Address of Facility untt Funeral Home . O. Box 156, Waldon	of, MD 2	0604	
ĺ.			23a. Part1. Enter the disease, or complications that caused the death. Do not enshock, or heart failure. List only one cause on each line.	nter the mode of dying, such as cardiac or r	espiratory arrest,		Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death) a	liomyopathy			hears
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,092	ite be executed ysician and ne burial-transit	al Ex	resulting in death) Last Due to (or as a consequence of):				
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	The law requires that the death certifica tte has been signed by the attending ph page 2 should be detached for use as t	Physician/M	in the pact 12 months?	☐ Ectopic pregnancy ☐ Other (specify)		Month	Day Year
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	ires that signed b	by	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	1 Tes	co use contribute to	bably 4 Minknown
Sorc	w requir been si should I	etec	Hypertension		24a. Was an		
Records,	The law cate has page 2	ompleted			autopsy performed	prior to co death?	opsy findings available empletion of cause of
Vital		e C	25. Was case referred to medical	26. Place of Death (0	1 ☐ Yes 2 🔀	No 1 ☐ Yes	2□ No
Ž	ys dis	To B	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient	ent 3 DOA Other: 4 Nursing Home	5 X Residence	e 6 □Other (Speci	ify)
n of	ding Pth h. After th funeral		27. Manner of Death 1 Natural 5 □ Pending 28a. Date of Injury (Month, Day Year) 28b. Time Injury	Work?	d. Describe how i	njury occurred	
isio	Attending or death. ector: After by the fune	Icatl	2 Accident investigation 3 Suicide 6 Could not be 288 Riago of Injury. At home farm a	M 1 Yes 2 Kio	Location /Stree	t and Number or Rur	al Route Number
Division	or Attendate death Director:	Certification:	4 Homicide determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)	areet, factory, office	City or Town, S	tate)	ar ribble ramber,
	To the Hospital or within 24 hours after To the Funeral Director completely filled in b		29a. Certifier 12 Certifying Physician: To the best of my knowledge, dea	ath occurred at the time, date and place, and	due to the caus	e(s) and manner as	stated.
	the Ho in 24 the Fu	Medical	(Check only one) 2 Medical Examinar: On the basis of examination and/or and manner stated.				
	日報日あて	2	29b. Signature and title of certifier SILL N SIN hot MD	29c. License number		Date signed (Month,	
	14		20. Name and address of names who completed source of death (Name 22-) (True	MD D00510	15	11 04	2004
Y	BIN		30. Name and address of person who completed cause of death (Item 23a) (Type Ellen Pinhelt 6900 Georgia 31. Date filed (Month, Day, Year) NOV 0 5 2004 32. Tegistrar's Signature	Ave NW Washing 1	on DC	20307	
4	Sta	ate	31. Date filed (Month, Day, Year) 32. Tagistrar's Signature	books			
	Regist	rar	NOV 0 5 2004				

State of Maryland / Department of Health and Mental Hygienes 1 - For State Registra Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** RICHARD WINKELMAYER, M.D. 11 2004 1302 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Atlantic General Hospital Berlin Worcester 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Yea 3/4/1930 Birthplece (State or Foreign Country) **Funeral X** M 2□ F 146-32-3248 74 Director Austria Usual Residence of Decedent 10a State 10c. City, Town or Location 10b. County 10d. Inside City Limits 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Heatith and Mential Hygiene. Important: If item 27 is marked other than "natural", or Itams 23a or 28a-1 show any injury or other traumatic event, the Medical Examinal must be notified at 1X Yes 2 □ No Completed by Funeral Director Worcester Ocean Pines 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 79 Brandywine Dr. 21811 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2XNo White Specify: Specify: 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a, Decedent's Usual Occupation 16h Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) **Psychiatrist** Hospital 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Franz Winkelmayer Maria Perschinka 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia Winkelmayer 79 Brandywine Dr. Ocean Pines, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 11/8/04 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Frankford, DE Cape Henlopen Crematory 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility The Burbage Funeral Home 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. On not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition **Physician** encumonia resulting in death) /Medical ue to (or as a consequence of): Examiner Seg 515 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner the death certificate be executed and resulting in death) Last Due to (or as a consequence of): the attending physician Completed by Physician/Medical رة) //// 3. Box 687 IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 □Ectopic pregnancy detached for Day Month Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No o 9 Unknown 9 Unknown signed by م The law requires that Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, pe 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown been: 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an has autopsy performed certificate 2 ☑No Vital 1 ☐ Yes Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) /2 **□**₩6 2 ER/Outpatient 1 Tes 1 Inpatient 3□ DOA Medical Certification: To (his ō 27. Mann of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred on o 1 Natural 5 Pending investigation death. 1 Yes 2 No 2 Accident S 6 ☐ Could not be 3 🗌 Suicide 28e. Ptace of tnjury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 0 24 hours a 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicates aminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. within 2 To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 53612 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ealthway Pr. Berlin, MO2(911 Indrea MO 31. Date filed (Month, Day, Year) 32. Registrar's Signature State NOV 0 9 Registrar

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			1- For State of Maryland / Department of Health an Certificate of Death	d Mental Hy	gien 2004 36855
	Physici	an	1. Decedent's Name (First, Middle, Last)	2. Date of Dea	ath 3. Time of Death Day Year
	/Medic	al	Joni Adrienne Weimer	Novembe	r 3 2004 8:23 A ^M
1	Examin	er	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of D	Death	4c. County of Death
	Funeral		91 Meadowlark Avenue Mt. Airy 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24	Hrs. 8. Date of Birt	th 9 Birthplace (State or Foreign
	Director		221-44-7177 1 M 2 X F 47 47 Months Days Hours M	Min. (Month, Da) Dec. 2	y, Year) Country)
	pu »		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location		
	ahovia short	ō	Y 1 1 2 2 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		10d. Inside City Limits 1 ☑ Yes 2 ☐ No
	28a-1	ect	Maryland Carroll Mt. Airy 10e. Street and Number 10f. Zip Code		10g. Citizen of What Country?
	3a or	Funeral Director	91 Meadowlark Avenue 21771		United States
	ma 2	nera	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin	? (Specify Yes or No-	
9	or Ite		Armed Forces? 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No If Yes, specify Cuban, Mexican, P 1 ☐ Yes, 2 ☑ No If Yes, specify Cuban, Mexican, P	uerto Rican, etc.)	
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12	filed within Hygiene.	шо	Elementary/Secondary (0-12) College (1-4or 5+) Floral Designer		Flower
Þ	be filed within 72 hours after deeth with the Marylan ital Hygiene. ed other than instural; or flema 23a or 28a-1 show event, the Madical Extribution must be notified at	BeC		Name (First, Middle,	
Maryland	2 should be to and Mental Hamarked of Iamarked or raumatic eva	10	Carol Presson Oakley Joan	Moritz	
Jar	d 2 should th and Mer 7 la marke traumatic	0.00	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number of		
	os 1 and 2 of Health itam 27 l		Joan M. Oakley / Mother 200 Commerce Street 20a. Method of Disposition 20b. Place of Disposition (Name of	Harringto	on, Delaware 19952
Baltimore,	20 0		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place)	ovember	20c. Location - City or Town, State
Ħ	# 문문를	1		4, 2004	Frederick, Maryland
B	permi Depa Impo any ii	1, 33			uneral Homes, P.A. Airy, Maryland 21771
		1	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as car shock, or heart failute. List only one cause on each line.		
	Pnysician		Immediate Cause (Final disease or condition a. Renal Cell (ARC)	homa	Onset and Death
	/Medical Examiner		resulting in death) Due to (or as a consequence of):	., ., .,,	
	LAGITITICI	_	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):		
	ted nsit	Examine	Cause (Disease or injury		1
,	be executed sician and burial-transit	Exal	that initiated events c		
8760,	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	dicail	d		
9	rtifica ng ph s as th		IF FEMALE:		
Вох	eath certific attending p	lan/	23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1		23d. Date of delivery
0	by the a	Physician/Me	1 Yes 2 No 4 Pregnant at time of death 5 Other (specify)		Month Day Year
σ.	that the		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did to	bacco use contribute to the cause of death?
rds,	quires n sign ald be	d by			es 2□No 3□Probably 4▼Unknown
CO	law requir as been si 2 should	ojete		24a. Was a	
Vital Record	The te ha	Completed		autop perfor	sy prior to completion of cause of
ita	ician: certifica ector, p	Bec	25. Was case referred to medical examiner? 26. Place of	1 ☐ Yes Death Check only of	
of V	Physician: this certific ral director,	은	1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursin	ng Home 5 Resid	ence 6 Other (Specify)
	ing After une	ion:	27. Manner Death 1 atural 5 Pending 28a. Date of Injury 28b. Time of Injury 28b. Time of Injury 28c. Injury at Work?	28d. Describe h	ow injury occurred
Division	Attanding r death. sector: After by the funer	ertification:	2 Accident investigation 3 Suicide 6 Could not be determined of the country of th	29f Location /S	Small and Number of Confession
Ο̈́	in the	ertif	4 Homicide determined determined building, etc. (Specify)	City or Tow	treet and Number or Rural Route Number, n, State)
	Hospital or 24 hours afte Funeral Dir tely filled in	sai C	29a. Certifier (Check only Check only 2 Medical Exeminer: On the basis of examination and/or investigation in my onition death of	lace, and due to the o	eause(s) and manner as stated.
	To the Hos within 24 h To tha Fur completely	ledical	one) and manner stated.	occurred at the time, o	date and place, and due to the cause(s)
	wit To Con	Σ	29b. Signature and title of certifier 29c. License number		29d. Date signed (Month, Day, Year)
•			- 100 Jenne W2 0101-041458		11-4-04
	15		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NICHOLAS W. Gemma ND 1870 Amnerst St, Sk. F 31. Date filed (Month, Day, Year) 32. Registrar's Signature	Minenas	er. Va. 22601
	Sta	te	31. Date filed (Month, Day, Year) 32. Registrar's Signature Sports Sports Sports	2011101631	
	Registr	ar	NOV 0 5 2004 Denne & Sparks.		

State of Maryland / Department of Health and Mental Hygien 2004 1 - For State Registrar 36856 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** A M Rippo Wagoner October 29,2004 8:15 Paula /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Frederick Frederick Memorial Hospital Frederick If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🖾 F 74 Director 105-22-5209 14, 1930 New York Usual Residence of Decedent with the Maryland 10c. City. Town or Location 10a State 10b. County 10d. Inside City Limits 28a-1 show other traumatic event, the Medical Examinar must be notified at 1787Yes 2 □ No Director Maryland Frederick Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ŏ 1000 D Heather Ridge Drive, Apt. 112 or Itams 23a 21702 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No White þ Specify: 3 ₩Widowed 4 □ Divorced "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "na any injury or other traumatic event, the Madic once. (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 5+ Nurse State Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Ferindo Alfonsi Camille Rippa 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dana Wagoner / Son 1000 D Heather Ridge Dr., #112: Frederick, MD 21702 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State November 6, 1 Burial 2 □ Cremation 3 □ Removal from State * 4 □ Donation 5 □ Other (Specify) Resthaven Mem. Gardens Frederick, Maryland 2004 21. Signature of Fun and Service Lie Resthaven Funeral Services, Skkot Cody P.A. 9501 Catoctin Mtn. Hwy. Frederick, MD 21701 23a. Part1. Enter the disease, or composhock, or heart failure. List only procations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest one cause on each line. Approximate Interval Between Onset and Death tmmediate Cause (Final Physician disease or condition resulting in death) /Medical as a consequence of) **Examiner** Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury Examine certificate be executed burial-transit that initiated events Due to (or as a consequence of) the attending physician and resulting in death) Last Box 68760 Physician/Medical use as the IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23h. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Day 5 Other (specify) Records, P.O. ☐ Yes 2 No detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? pe, þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 2 **D**No 1 Yes Division of Vital Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Dther: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 patient 2 ER/Outpatient 2 3□ DOA funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: After Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier lens 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Brekeret Ml. UNO4 sedarmo 31. Date filed (Month, Day, Year) 32. Registrar's Signature State NOV 05 2004 Registrar

			For State Registrar	State of M	aryland /		artment of I				ene 01)4	36857	1
			1. Decedent's Name (First, Middle, La	ast)						2. Date of Death Month		Yeer	3. Time of Death	
	Physicia /Medic		Calvin	Lee	Ward	l .				Novembe:		2004	4:14 a h	A
	Examin		4a. Facility Name (If not institution, gir	ve street and number,)		4b. City, Town,	or Location of	of Death		4c. County	of Death		
			Calvert Memorial				Prince				Cal	vert		
	Funeral Director		220-30-7059	Sex 7. A 1 ☑ M 2 ☐ F	ge (In yrs. last bi	Yrs.	If Under 1 Year Months Days		Min.	8. Date of Birth (Month, Day, July 6,	^{Year)} 1933	Cou	place (State or Foreig ntry) y Land	n
	and *		Usual Residence of Decedent 10a. State 10b. County		10c. City, Tov	vn or L	ocation						10d. Inside City Limits	s
	72 hours after death with the Maryland natural; or items 23a or 28a-f show dical Examinant ke multhed at	ō	MD Calve	rt			Owings	2					1 ☐ Yes 2 ☑ No	0
	28a-	Funeral Director	10e. Street and Number	LC			10f. Zip Code			10	g. Citizen of	What Cou	ntry?	_
	with Sa or			J Dood			20736					USA		
	Jeath Ins 20	era	1819 John C. Ward	12. Was Decedent	Ever in U.S.	13.	Was Decedent of	Hispanic Ori	gin? (Spe	cify Yes or No-	14. Ra	e - Amer	can Indian,	_
(0	r iter	교	1 ☐ Never Married 2 M Married	Armed Forces 1 ∑Yes 2 ☐ If Yes, Give	? No		If Yes, specify Cut			Rican, etc.)		ck, White	, etc.	
8	ali, c	þ	3 ☐ Widowed 4 ☐ Divorced	Year or Dates:	1953-55		1 ☐ Yes 2 🛱 No	Specify:			Specif	wh.	ite	
5-0036	natu Ilcel	Completed	15. Decedent's E (Specify only highest gi	ducation		a. Dece	dent's Usual Occu kind of work done DO NOT use retire	pation during mos	t of workii	ng i	6b. Kind of B	usiness/Ir	ndustry	
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2	filed w Hygier other th		12	A)		fa	armer	10 Math	ada Nama	(Cient Middle 1		icul	ture	
and	be fill	Be	17. Father's Name (First, Middle, Las		3					(First, Middle, N	iaiden Sumai		[rott	
Maryland	should beind Ments marked umatic	မ	John Cephas 19a. Informant's Name/Relationship		rd	b Maili	ng Address (Stree		nie	l Pouto Numbor	City or Tourn			
Ma	d 2 sl than 7 isr		_				John C.					0736	, ,	
	1 an Heal em 2		Jane Ward, spous	<u>e</u>	20b. Place	of Disp	osition (Name of				Oc. Location		own, State	_
ō	ages nt of t; if it		1 Burial 2 □ Cremation 3 0 '4 □ Donation 5 □ Other (Spec		9		matory or other pla ip Cemet	· 1	11_0	8-2004	Friend	Rehir	. MD	
altimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: if item 27 is marked other than "natural", or items 23a or 28a-f show any fourty or other traumatic event, the Medical Examinar mast be rediffied at ances.		21. Signature of Funeral Service Lice		11161	-	2. Name and Addr	-		0 2001	111011	, CITT	, 12,	7
Ba	permit. Departr Importe any Inj		1 William R	Gar		R	ausch Fu	neral	Hone	P.A.,	Owings	s, ML	20736	
			23a. Part1. Enter the disease, or cor shock, or heart failure. List only	nplications that cause	d the death. Do							1	Approximate Interval Between	
	Physician		Immediate Cause (Final	A C		M.	ocendia	o ir	for	retron			Onset and Death	
4	/Medical		disease or condition resulting in death)	Due to (or a	s a consequence				1	*****************		-		
н	Examiner		Sequentially list conditions	b. Co	morere	m	arsto	me	dis	ease			2-3 year	3
	p =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or a	s a consequence	0(/)		1						-
	ecute and trans	Examin	that initiated events resulting in death) Last	C. Due to for a	s a consequence	of).								
60,	cate be executed physician and the burial-transit	E		Due 10 (01 a	s a consequence	oi).								
8760,	requires that the death certificate be executen signed by the attending physician and nould be detached for use as the burial-trad	dicai	•	d										
9 X	leath certifica attending ph I for use as th	Physician/Me	IF FEMALE:	23c. If yes, outcom-	e of pregnancy						23d Da	te of deliv	renv	
Вох	atten for u	cian	23b. Was decedent pregnant in the past 12 months?	1 □Live birth	2 Fetal deat at time of death		□Ectopic pregnand □ Other (specify) _	Э				onth	Day Year	
P.O.	the d y the	ıysi	1 □ Yes 2 No 9 □ Unknown	9□ Unknown										
	res that the de signed by the a l be detached f	by PI	Part II. Other significant conditions	contributing to death	but not resulting	in the u	inderlying cause g	ven in Part I		23e. Did tob	acco use con	tribute to	the cause of death?	
rds	quire n sig uld b	pa pa								1 X Ye	s 2□No	3 ☐ Pro	bably 4 □Unknow	n
ပ္သ		Completed								24a. Was ar		Were aut	opsy findings available	е
æ	siclen: The law certificate has b lirector, page 2 s	E					-			perform	ed?	death?	20 No	
ita	len: rtifica stor, p	Bec	25. Was case referred to medical examiner?					26. Place	of Death	(Check only one				
1	Physiclen: this certific ral director,	오	1 ☐ Yes 2 No	Hospital: 1 Inpat	1-1-		III JUON		ursing Hor	ne 5 🗆 Reside	nce 6 □Oth	ner (Speci	fy)	
0	ding Physiclen: h. After this certific funeral director,		27. Manner of Death 1 Natural 5 Pending	28a. Date of Inj (Month, D	ury 28b. ay Year)	Time o	We	ork?		28d. Describe ho	w injury occur	red		
sio	tendi leath. tor: A the fu	cati	2 Accident investigati 3 Suicide 6 Could not	h.]Yes 2□		206 1		han an (1)	al Cauta Mumba	_
Division of Vital Records,	or At fter d Direct in by	Certification;	4 Homicide determine	d 280. Place of in	njury - At home, i etc. <i>(Specity)</i>	tarm, st	reet, factory, office		1	City or Town	State)	oer or Hur	al Route Number,	
	pitel ours a erel [ဦ	29a, Certifier Certifying F	Physicien: To the bes	t of my knowledg	no don	th occurred at the	ime date an	d place 3	and due to the co	uso(s) and m	annor as	stated	
	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: Atter completely filled in by the fune.	edical		miner: On the basis and manner s	of examination a									
	o the	Me	29b. Signature and title of certifier					se number		29	d. Date signe	d (Month,	Day, Year)	
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					geath (Item 23a) (Type	, Print)			0.1	tı			
	15+1		30. Name and address of person when the second seco	H WD	, 241	7	Solomin	15 Isla	and	Kd,	Hmtm	Stripe	n MD 20639	
	Sta		31. Date filed (Month, Day, Year)	32. Regis	tras Signature	L	1.0					, ,	20639	
	Regist	rar	1407 (J J ZUU4 🟲 🎤	LERELLE.	No.	MARCE	37					•	

			1 - For State of Maryland / De Registrar	partment of Health and ertificate of Death	Mental Hygie	ZHIU SHKAK
	Physici /Medic		1. Decedent's Name (First, Middle, Last) Doris Klesner Whitehurst		2. Date of Death Month November	Day Year 2, 2004 2:36 p M
H	Examir		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Deat	h	4c. County of Death
			Calvert Memorial Hospital 5. Social Security Number 6. Sex 7. Age (In yrs. last birthda	Prince Frederic		Calvert
	Funeral Director		579-07-1884 1□ M 2√ F 88 Yrs.	Months Days Hours Min.	(Month, Day, Ye	9. Birthplace (State or Foreign Country) 1916 Washington, DC
	pu »		Usual Residence of Decedent	Location	100. 201	22 - 12
	Aaryla Fahov	ō	MD Calvert Owin			10d. Inside City Limits 1 ☐ Yes 2 1 No
	the N	Director	10e. Street and Number	10f. Zip Code	10g.	Citizen of What Country?
	th with	ai Di	1160 Isabelle Drive	20736		U.S.A.
	r deal	Funerai	11. Marital Status 12. Was Decedent Ever in U.S. 1 Armed Forces?	3. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puer	Specify Yes or No- to Rican, etc.)	14. Race - American Indian, Black, White, etc.
36	rs afte	by F	1 □ Never Married 2 □ Married 1 □ Yes 2 5 No If Yes, Give ↑ 3 □ Widowed 4 □ Divorced Year or Dates:	1 ☐ Yes 2 No Specify:		Specify: white
215-0036	72 hours after death with the Maryland natural, or items 23e or 28e-f ahow incal Examinat must be invitified at		15. Decedent's Education 16a. De	cedent's Usual Occupation	166	. Kind of Business/Industry
215	ithin 7 9e. Nan "n	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	ve kind of work done during most of wo DO NOT use retired)	rking	
2	filed within Hygiene. Ither than "			oanquet manager	(First Middle Mail	restaurant
anc	d be fi	o Be	17. Father's Name (First, Middle, Last) Karl Alfred Klesner	Anna	me (First, Middle, Maid Cady	den Sumame)
ar J	s 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hyglene. itam 27 is marked other than "netural", or items 23e or 28e-f ahow other traumetic event, the Macdical Examination and by multilled at	F		iling Address (Street and Number or Re		ty or Town, State, Zip Code)
ž	and 2 ealth a n 27 is		Karla M. Berezoski, daughter 116) Isabelle Dr., Ow	ings, MD	20736
Baltimore, Maryland 21	0 0		1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State	position (Name of rematory or other place)		. Location - City or Town, State
Ħ			`4 Donation 5 Other (Specify) St. John		05/2004 Pr	ince Frederick, MD
Ba	permit. Departr Importa any inju		21. Signature of Funeral Service Licensee	22. Name and Address of Facility	~ D % O	ND 20726
	*		23a, Part1. Enter the disease, or complications that caused the death. Do not e	Rausch Funeral Hom onter the mode of dying, such as cardiac		Approximate
	Pnysician		shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition	iro milmonomi di ac		Interval Between Onset and Death
	/Medical Examiner		resulting in death) a. CITO TO COSTUDE Due to (or as a consequence of):	ive pulmonary dise	180	years
		-	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):			
	uted d ansit	Examine	cause (Disease or injury			
o,	ate be executed hysician and the burial-transit	Еха	resulting in death) Last Due to (or as a consequence of):			
8760	ate hy:	dical	d.			
9 X	eath certific attending p		IF FEMALE: 23c. If yes, outcome of pregnancy	17.		22d Date of delivery
ВОХ	death a atter d for u	Physician/Me	1 Live birth 2 Fetal death 3 in the past 12 months? 1 Yes 2 No. 4 Pregnant at time of death 5	B Ectopic pregnancy Other (specify)		23d. Date of delivery Month Day Year
J.	at the de by the a	hys	9 Unknown 9U Onknown			
	The law requires that the death certific tle has been signed by the attending p page 2 should be detached for use as	by	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.		to use contribute to the cause of death?
ecords,	w requir been si should	eted				2 No 3 Probably 4 Unknown
ž	The law	Completed			24a. Was an autopsy performed	24b. Were autopsy findings available prior to completion of cause of death?
Vital H	(0 -	a	25. Was case referred to medical	26 Place of Dea	1 ☐ Yes 2 💢	No 1 ☐ Yes 2 ☐ No
	nyaici nis cer direct	To B	examiner? 1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpat.		lome 5 Residence	6 ☐ Other (Specify)
n of	ding Ph h. After thi funeral		27. Manner of Death 1 XNatural 5 ☐ Pending 28a. Date of Injury (Month, Day Year) 28b. Time Injury	of 28c. Injury at Work?	28d. Describe how in	
Division	deat deat ctor: / the	ertification;	2 Accident investigation 3 Suicide 6 Could not be determined determined 28e. Place of Injury - At home, farm,	M 1 Yes 2 No	28f Location (Street	and Number or Rural Route Number,
2	al or At s after o I Dirac d in by	ertii	4 Homicide determined building, etc. (Specify)	, iaday, and	City or Town, St	are)
	To the Hospital or A within 24 hours after To the Funarel Dirac completely filled in by	edical C	29a. Certifier (Check only (Ch	ath occurred at the time, date and place investigation, in my opinion, death occu	, and due to the cause rred at the time, date a	(s) and manner as stated. and place, and due to the cause(s)
	thin 2 thin 2 tha	Med	one) and manner stated. 29b. Signatur and title of certifier	29c. License number		Date signed (Month, Day, Year)
)	F ≯ F 8		I tille me	1D D40370		vember 3, 2004
	. 1		30. Name and address of person who completed cause of death (Item 23a) (Typ		140	2004
	10		Peter Wisniewski, M.D. 110 Hospit	al Rd., Prince Fre	ederick, M	20678
	Sta Registr		Peter Wisniewski, M.D. 110 Hospit 31. Date filed (Month, Day, Year) 32. Registrate Signature	Sparle		
			1 A T PAGE 1	-/		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienes For State Registrar 36859 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death October 31. **Physician** 2004 Jane S. Wicks 10:40 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Annapolis

If Under 1 Year | If Under 24 Hrs.

Months | Days | House | Ginger Cove Health Center Anne Arundel 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Security Number 6. Sex **Funeral** 1 □ M 2 KN Yrs. 87 Director 022-01-3597 1, 1917 Massachusetts Usual Residence of Decedent 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits 28a-f show other traumatic evant, the Medical Examiner must be notified at 1 ☐ Yes 2 X No Director Maryland Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6 natural', or Itams 23a 2212 River Crescent Drive 21401 United States by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status ges 1 and 2 should be filed within 72 hours after c t of Health and Mental Hygiene. If Itam 27 is marked othar than "natural", or Itar 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: White 3 Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ivanhoe Harrison Sclater Ida Hannaford 19a. Informant's Name/Relationship (Type, Print) Daugh ter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1005 Penny Drive Jacqueline G. Eastman /-in-Law Stevensville, Maryland 21666 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1 Department of H Important: If Ital any injury or oth 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) Baltimore Crematory 11/2/2004 Baltimore, Maryland 21. Signature of Figne A Service License 22. Name and Address of Facility John M. Taylor Funeral Home, Inc Alon 147 Duke of Gloucester St. Annapolis, MD 21401 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician LYMPHOMA Jenn /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to for as a consequence of Examiner The law requires that the death certificate be executed burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 the attending physicien Physician/Medical use as the 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Month Day Year 4 Pregnant at time of death 5 Other (specify) detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No 2 No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After Injury 1 Natural 2 Accident 5 Pending after death. 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide tha Hospital within 24 hours a To the Funeral C 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Dale signed (Month, Day, Year) 124768 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) FARM Rd. 21012 am ARNOLD DABBS, win 277 TENINIHLA 31. Date filed (Month, Day, Year) 32 Registrar's Signature State Registrar NOV - 3 200

JD			1 - State of Maryland / Department of Maryland	artment of F rtificate of	lealth and M <i>Death</i>	fental Hygid	ene2004	36860
	Physici		1. Decedent's Name (First, Middle, Last) Jacklyn Kay Yerkie			2. Date of Death OCTOber	Day 22, 2004	3. Time of Death
	/Medio Examin		4a. Facility Name (It not institution, give street and number) Prince Georges Hospital Center	4b. City, Town, o	or Location of Death		4c. County of Death Prince Geo	
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1 1 − 35 − 6478 1 1 9 Yrs.	If Under 1 Year Months Days		8. Date of Birth April 2		Nace (State or Foreign
probable of the	Piled at	tor	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Lo Maryland Prince George Clintor				1	0d. Inside City Limits 1 ☐ Yes 2X No
	3e or 28	Il Director	10e. Street and Number 2305 Floral Park Road	10f. Zip Code 2073	35		g. Citizen of What Cour	itry?
020	is I and 2 should be lied within 72 flouts aller bearn with the maryland. The alth and Mental Hygiene. I the Maryland 127 is marked other than "natural", or liems 23e or 28e-f ehow other traumetic evant, the Maryland Examiner must be notilled at	by Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ ▼No		Hispanic Origin? (Span, Mexican, Puerto		14. Race - Americ Black, White, Specify.Whit	etc.
200-C 7	Within 75 there and the water a than "natura is Medical E	Completed		dent's Usual Occup kind of work done DO NOT use retired	pation during most of work d)	ing	Sb. Kind of Business/Ind	dustry
מוומ ל	ntal Hygie ad other:	Be	17. Father's Name (First, Middle, Last) John William Yerkie, III	ident		e M. Hi	,	
2 3	and and signal	2	19a. Informant's Name/Relationship (Type, Print) 19b. Mailin		and Number or Rura	al Route Number, (City or Town, State, Zip	
. ע	rages I and not of Health out: If item 27 iry or other tra		Dorothy B. Yerkie Grandmother 2 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 20b. Place of Disposition cometery, cremation 4 The Company of th	sition (Name of		Date 20	c. Location - City or To	wn, State
	perimit. Pages Department of h Importent: if its any injury or ot		21. Signature of Funeral Service Licensee	2. Name and Addre Llliams	ss of Facility Funeral	Home,	ively, Vi	20640
	nysician /Medical Examiner		23a. Part1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a	er the mode of dyir	ng, such as cardiac o	or respiratory arres	ian Head,	Approximate Interval Between Onset and Death
Ņ	physician and sthe burial-transit	cal Examiner	Sequentially list conditions, it any leading to kinn of all cause. Enter Underlying Cause. (Disease or injury that initiated events resulting in death) Last b. Due to (it as a consequence of): c. Due to (or as a consequence of):					
The law requires that the death confficence	signed by the attending phy d be detached for use as th	Physician/Medl	4 Pregnant at time of death 5	Ectopic pregnancy Other (specify)	/	,	23d. Date of delive Month	ry Day Year
or designed that	been signed by should be deta	by	Part II. Other significant conditions contributing to death but not resulting in the un	nderlying cause giv	en in Part I.	23e. Did tobac	cco use contribute to th	
		Completed	•			24a. Was an autopsy performe	prior to con death?	osy findings available inpletion of cause of
To the Hosnital or Attanding Physician:	r this certific	To Be	25. Was base referred to medical examiner? 1 № Yes 2 □ No 1 □ Inpatient ★□ ER/Outpatien 27. Manner of Death 28a. Date of Injury 28b. Time of	28c. Injur	v at		ce 6 Other (Specify)
Attending	after death. Director: After thin by the funeral	Iffication:	1 Natural 5 Pending investigation 3 Suicide 4 Homicide Could not be determined (Month, Day Year) Injury 1 Old 1 Ol	11	k? Yes 2 XNo 1	Viver of Au	ro involved in	Doube Mumber
Z vo istingo	within 24 hours after death. To the Funeral Director; A completely filled in by the fu	edical CertIf	29a. Certifier (Check only (Check only Medical Examiner: On the basis of examination and/or in	n occurred at the tin	me, date and place, a	and due to the caus	State) Beyly RAD	ated
Tothe	within 24 To the F complete	Medi	29b. Signature and title of certifier	29c. Licens O.C.M	e number	29d	Date signed (Month, Ectober 23,	Day, Year)
	<u>.</u>		30. Name and address of person who completed cause of death (Item 23a) (Type, I				more, Maryl	
			21 Date filed (Month Day Year)	-				

Registrar

NOV 1 9 2004

State of Maryland / Department of Health and Mental Hygiene 36861 For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** MT1704/2004 Albert. Yates 2:40 P M John /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince George's Ft. Washington Millenium Health & Rehab. Ctr. If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Months Days Hours XØX 2□F 1072674905 Maryland Yrs. 579-44-9110 Director Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits or than "natural", or Items 23a or 28a-f show the Medical Exprenent rust be notified at Ft. Washington 1 Yes 2XXX Maryland Prince George's by Funeral Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20744 USA 13003 Monroe Avenue filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 █ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: White Specify. XXIWidowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Taxi Cab Driver Transportation permit. Pages 1 and 2 should be filed v
Department of Health and Mental Hygies
Important: If Item 27 is marked other tl
any injury or other traumatic event. The 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Frances Ruth Bailey Charles J. Yates 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Mary A. Certo / Daughter 13003 Monroe Avenue Ft. Washington, M.D. 20744 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location · City or Town, State 1 Burial 2 KK mation 3 Removal from State 11/05/2004 Edgewater, Maryland Kalas Crematory * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name @ Cotton Packalas Funeral Home PA 6160 Oxon Hill Road Oxon Hill, Maryland 20745 xxw ann 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of hijury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner burial-transit and Due to (or as a consequence of): Box 68760. Be Completed by Physician/Medical the for use as IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Month Year 4☐Pregnant at time of death 5 Other (specify) signed by the a P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Winknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy CONGESTIVE performed' HEART PAILURE 2□ No 2 X No 1 Yes 1 Yes Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 | Inpatient 1 ☐ Yes 2 📉 Other: XX Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA Certification: To this 27. Manner of Death 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After or Attending 5 Pending investigation uneral Director: At liled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral L 29a. Certifier 1XX crtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier PMYSICI AN 100053782 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LIVINGSTON ST. , SUITE #101, FT. WASH. 11701 SURESH VORGHESE 31. Date filed (Month, Day, Year, NOV 0 8 2 Registrar's Signature State 8 2004 Registrar

			State of Maryland / De	partment of Health and M	lental Hygier	2004 36862
			1. Decedent's Name (First, Middle, Last)	ertificate of Death	Reg. i	
	Physici		Barbara Ann Zvirblis		Month I	Day Year
	/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	October	31, 2004 7:58 A " 4c. County of Death
			705 Cannon Rd.	Silver Spring		Montgomery
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda		8. Date of Birth (Month, Day, Yea	ar) 9. Birthplace (State or Foreign Country)
	Director		212-48-7274		May 11, 19	946 Maryland
	/land		10a. State 10b. County 10c. City, Town or	Location		10d. Inside City Limits
	a-fsh	tor	Maryland Montgomery Silver Sr	ring		1 X Yes 2 ☐ No
	or 28	Director	10e. Street and Number	10f. Zip Code	10g. (Citizen of What Country?
	ath w	rail	705 Cannon Rd.	20904	US	SA
	ltams	Funeral	Armed Forces?	 Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto 	ecify Yes or No- Rican, etc.)	 Race - American Indian, Black, White, etc.
920	urs af	by F	1 Never Married 2 Married 1 Yes 2 No If Yes, Give 3 Widowed 4 Divorced Year or Dates:	1 ☐ Yes 2 X No Specify:		Specify: White
21215-0036	within 72 hours after death with the Maryland ene. than "natural", or Itams 23a or 28a-f show te Medical Eva ulter must be notified at	Completed	15. Decedent's Education 16a. Dec (Specify only highest grade completed) (Gi	cedent's Usual Occupation work of working the control of work done during most of working the control of working t	16b.	. Kind of Business/Industry
2	nithin ne. ne.	mple	Flementary/Secondary (0-12) College (1-4or 5-)	DO NOT use retired) ram Associate	•	ASHA
	iled w Hygien Ihar ti	ပ္ပ	4 Yrs.	·	(First, Middle, Maid	
and	d be f antal h cad of	o Be	Peter Zvirblis	Ivy Kibbl		en Sumame)
Maryland	shoul nd Me mark umari	To		iling Address (Street and Number or Rura		y or Town, State, Zip Code)
	and 2 alth a 27 is			Cannon Rd. Silver S		
ore	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other treumatic avant. It e Medical Evaniret must be notified at once.		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 20b. Place of Discemetery, co	position (Name of Dematory or other place)	ate 20c.	Location - City or Town, State
Baltimore,	Pag Iment Iant: I		`4 □Donation 5 □ Other (Specify) Ft. Line	oln Crematory 11/05	/2004 Bre	entwood, MD
Bai	Depar Mpor My in		21. Signature of Funeral Service Licensee	22. Name and Address of Facility Hine	es-Rinaldi	Funeral Home
	10140		23a. Part1. Enter the disease, or complications that caused the death. Do not e			ver Spring, MD 20904 Approximate
ŀ	Dhusisian		snock, or heart failure. List only one cause on each line.		respiratory arrest,	Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death) Metastatic Brea	st Carcinoma		
	Examiner					
	י ש י≡	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Unsease or injury)			
	and and -trans	Examiner	Cause Disease or injury that initiated events resulting in death) Last C			
68760,	icate be executed physician and s the burial-transit	aiE	Due to (or as a consequence or).			
687	ficate g phys	edicai	d			
Вох	res that the death certificated by the attending be detached for use a	n/M	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy			23d. Date of delivery
m.	death	Physician/M	1 Yes 2 No	☐ Ectopic pregnancy ☐ Other (specify)		Month Day Year
<u>Р</u> О	at the	Phys	9 🗆 Onknown			
	law requires that the death certii as been signed by the attending 2 should be detached for use a	by	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.		o use contribute to the cause of death? 2 \$\frac{1}{2}\$\text{No} 3 \$\sumsymbol{\text{Probably}}\$ 4 \$\sumsymbol{\text{Unknown}}\$
Š	w requir been si should I	etec			1 Tyes	X
Vital Records,	9 - 6	Completed			24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
a	ician: Th certificate ector, pag	a)	25. Was case referred to medical	26. Place of Death	performed?	No 1 Yes 2 No
>	ysician: is certific director,	O B	examiner? 1 ☐ Yes 2X No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpati	Othor		6 □Other (Specify)
0 0	Attending Physician: r death. actor: After this certification the funeral director.	Di: T	27. Manner of Death 1 ☐ Natural 5 ☐ Pending (Month, Day Year) 28a. Date of Injury (Month, Day Year) Injury	of 28c. Injury at 2	28d. Describe how inj	
Sio	r Attendii er death. ractor: A by the fu	catio	2 Accident investigation	M 1 Yes 2 No		
Division of	= 9.5 -	ertification:	determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)	treet, factory, office 2	28f. Location (Street a City or Town, Sta	and Number or Rural Route Number, ite)
	spital	O	29a. Certifier 1 Certifying Physician: To the best of my knowledge, dea	ath occurred at the time, date and place, a	nd due to the cause/	(s) and manner as stated
	To the Hospital or within 24 hours after To the Funeral Dir completely filled in	edical	(Check only 2 Medical Examiner: On the basis of examination and/or one)	nvestigation, in my opinion, death occurre	d at the time, date a	nd place, and due to the cause(s)
	To the within To the comp	M	29b. Signature and title of certifier	29c. License number	29d. D	Date signed (Month, Day, Year)
			1 Tom / has	D0041373	1	1/2/2004
	5	25	30. Name and address of person who completed cause of death (Item 23a) (Type Said Baidas, M.D. 3800 Reservoir Rd	N W Washington	DC 20007	
	-61	,	31. Date filed (Month, Day, Year) 32. Registrar's Signature	a	20007	
	Sta Registr		NOV 04 2004 Server 19	Sparks		

			1 - For State Registrar	State of Ma		epartment o Certificate	of Health and M of Death		eg. No. 2004	36863
	Physic /Medi		Decedent's Name (First, Middle, La	JEAN	M. AND			2. Date of Dea Month	th Day Year 19 - 2004	3. Time of Death 5:30 P. M
	Exami	М	4a. Facility Name (If not institution, giv 4212 KENSINGTO	N ROAD		E	WIN, or Location of Death BALTIMORE Year If Under 24 Hrs.		4c. County of Deat	MORE
	Funeral Director		5. Social Security Number 219-22-8145 1 Usual Residence of Decedent	□M XX F	e (In yrs. last birth 77 Yı	Months D	ays Hours Min.	8. Date of Birth (Month, Day 02-01-1	927 PENI	hplace (State or Foreign untry) NSYLVANIA
	Maryland t-f show	tor	10a. State 10b. County	IMORE	10c. City, Town		BALTIMORE			10d. Inside City Limits 1 ☐ Yes 2 XXVI
	death with the Maryland ms 23a or 28a-f show crivest be retified at	al Director	10e. Street and Number 4212 KENSINGTON	ROAD		10f. Zip Co	^{de} 21229	1	0g. Citizen of What Co	•
	ē 2 2	by Funeral	11. Marital Status 1 Never Married 3 Widowed 4 Divorced	12. Was Decedent & Armed Forces? 1 Yes 2 Y	Ever in U.S.	13. Was Decedent If Yes, specify	t of Hispanic Origin? (Spe Cuban, Mexican, Puerto No <i>Specify:</i>	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, White Specify:	
	Maryland 21215-0036 d 2 should be filed within 72 hours aft in and Mental Hygiene. 77 is marked other than "natural", or traumatic event, its Medicul Evant	Completed	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12) 12 YEARS	ducation de completed) College (1-4or 5		ecedent's Usual O Give kind of work d ife. DO NOT use n HOUSE	lone during most of worki etired)	ing	16b. Kind of Business/	,
	Maryland 2121 12 should be filed within n and Mental Hygiene. 7 is marked other than raumatic event, Italia.	To Be (17. Father's Name (First, Middle, Last)	WALLACE	BLACK		18. Mother's Name			
	and 2 sho		19a. Informant's Name/Relationship () 81 (Mailing Address (St 5 KELLOGG	reet and Number or Rura GROAD, LUTHE	RCVILL,	City or Town, State, Z	ip Code) 21093
00	Baltimore, Ma permit. Pages 1 and 2 s Department of Health at Important: If item 27 is any injury or other trau once.		20a. Method of Disposition 1 ☐ Burial 2XXCremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify		cemetery,	risposition (Name of crematory or other PSERVICE	place)		TOWSON, MAR	Fown, State RYLAND, 21204
ho	Balt permit. Depart Imports any inj		21. Signature of Funeral Service Licen	S88			ddress of Facility	HOME, IN	10	ORK ROAD
(a)	Physician /Medical Examiner		23a. Part1. Enter the disease, or com, shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a Chr	θ.	obstr	dying, such as cardiac o		est,	Approximate Interval Between Onset and Death
1912004	68760, ilicate be executed pphysician and as the burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	с.	a consequence of)					
ben		Medical	IF FEMALE:	d						
<i>Ио</i> Vем	ords, P.O. Box 6 requires that the death certifi een signed by the attending hould be detached for use as	hysician/M	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at 1 9 □ Unknown	2 Fetal death	3 ☐ Ectopic pregn: 5 ☐ Other (specify			23d. Date of delive Month	very Day Year
-	Cords, P	by P	Part II. Other significant conditions co	ontributing to death bu	t not resulting in th	ne underlying cause	given in Part I.	10	acco use contribute to s 2 □ No 3 □ Pro	
275	Rec	Completed						24a. Was an autopsy perform	ed? prior to co	opsy findings available ompletion of cause of
Ande	of Vi	ation: To Be	25. Was case referred to medical examiner? 1 Yes No 27. Manner of Death Natural 5 Pending investigation	28a. Date of Injury (Month, Day	nt 2 ☐ ER/Outpa / /ear) 28b. Tim Inju	e of 28c. I	26. Place of Death Other: 4 Nursing Hon njury at 2 Work? 1 Yes 2 No	ne 5 🗆 Resider		Daughteri residence
ean	Division Hospital or Attending 44 hours after death Funeral Director: After	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injurbuilding, etc.	ry - At home, farm, (Specify)	, street, factory, off	ice 2	8f. Location (Str. City or Town,	eet and Number or Rur State)	al Route Number,
1	To the Hospital within 24 hours of To the Funeral completely filled	edical	29a. Certifier (Check only one) 1.★ Certifying Phyone) 2 Medical Example 1.★ (Check only one)	vsician: To the best or iner: On the basis of and manner stat	examination and/o	eath occurred at the rinvestigation, in re	e time, date and place, a ny opinion, death occurre	nd due to the cared at the time, da	use(s) and manner as s te and place, and due t	stated. o the cause(s)
	To I with To I	Σ	29b. Signature and title of certifier Author	Mily.	und		ense number		d. Date signed (Month,	
/\	V		30. Name and address of person who do	Game	6701 N	pe, Print) - Charle	St. Bali	6. md	2120/	
	Sta Registr	rar	31. Date filed (Month, Day, Year) ¹	32. Registra	s Signature	B 4	ocks			

ORIGINAL

36864

		1 - State Registrar			C	ertificate of	Death	7		Reg. No.	0 7	00001
		1. Decedent's Name (First, Middle, L	ast)					:	2. Date of D	eath		3. Time of Death
Physic /Medi		HERBERT ALLEN							Month	Day	2004	1.15 PM
Exami		4a. Facility Name (If not institution, g.	ive street and number	r)		4b. City, Town,	or Location	of Death			ounty of Death	
		Frank lin Squ	are Hos	Di to	al	ROSE	dal	0		BO	11+:0	nose
Funeral			Sex 7. A		. last birthda		r If Unde		B. Date of Bi (Month, D	rth	9. Births	placa (State or Foreign
Director		213-09-4223	1⊠M 2□F	8	6 Yrs.	Months Days	Hours	Min.	pril '	7, 191	8 MARYI	ntry) [AND
Pu .		Usual Residence of Decedent 10a. State 10b. County		100 0	ih. Taua							
aryla ehov	2	1.00.000,	THORE	100. 0	city, Town or						1	10d. Inside City Limits
ith the Marylan or 28s-f ehow	Director		IMORE			ESSEX						1 Yes 2 XNo
vith to	듬	10e. Street and Number				10f. Zip Code				10g. Citizer	n of What Cour	ntry?
s 236	rai	1435 GOODWOOD AV				21221				U.S.A		
er de	Funeral	11. Marital Status	12. Was Deceden Armed Forces	?	U.S. 13	 Was Decedent of If Yes, specify Cu 	Hispanic O ban, Mexica	rigin? (Spec an, Puerto R	ify Yes or No ican, etc.)	D- 14.	Race - Americ Black, White,	
Maryland 21215-0036 4 2 should be filed within 72 hours after death with the Maryland th and Mental Hygiene. 7 Is marked other than "natural", or Items 23e or 28e-1 show treumatic event, the Madical Examinations to writing at	by F	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☐ If Yes, Give Year or Dates			1 ☐ Yes 2 🔀 No	Specify	<i>r</i> :		Sp	pecify: DT7	N CV
2 hou		15. Decedent's I			16a Dec	cedent's Usual Occu	mation			16h Kind	BLA	
D (215 215 With 72 8	Completed	(Specify only highest g	rade completed)		(Gi	ve kind of work done . DO NOT use retire	e durina mo	st of working	7	160. Kind	of Business/In	dustry
212 212 d with giene.	Eo	Elementary/Secondary (0-12)	College (1-4or	5+)	STEEL	WORKER	,			STE	EL INDU	ISTRY
Hyge at the state of the state	Be C	17. Father's Name (First, Middle, Las	t)				18. Moth	ner's Name (First, Middle	, Maiden Sui		
land land land land land land land land	To B	HERBERT W. ALLEN						ИЕ. Н			,	
laryland 212: 2 should be filed within and Mental Hygiene. Is marked other than aumatic event, the M	-	19a. Informant's Name/Relationship	(Type, Print)		19b. Ma	iling Address (Stree				er City or To	own State Zir	Code)
	1	ETHEL ALLEN/WIFE				GOODWOOI				E, MD	· ·	0000)
— 0, = # E E		20a. Method of Disposition		20b.		position (Name of rematory or other pla		Da	-		ion - City or To	own, State
		1 Burial 2 Cremation 3 Superior 2 Cremation 3 Superior 5 Other (Special Control		9			ace)	11 20	2004	Darm	THORE	1175
— → □ = ₽ ₽ ₽ ≥ □		21. Signatur of Funeral Service Lice		IUA		CEMETERY 22. Name and Addr	ess of Facil	11-20 lity	-2004	BALT	IMORE,	MD
Bal permi Depar Impo	. 5	they bear le			V	VILLIAM C 206 W. No	 BROV 	√N COM				
		23a. Fart1. Enter the disease, or conshock, or heart failure. List only	nplications that cause	ed the dea							D ZIZI	Approximate
(2755903	ŀ	shock, or heart failure. List only	one cause on each		159	Wike the Person.			,			Interval Between Onset and Death
Pnysician /Medical		disease or condition resulting in death)	a. 20 V	616		nem	a					
Examiner		1	Due to (or a	s a conse		000	0.00	0				
	-	Sequentially list conditions,	b. 17 C	s a consec		ic An	le m	ice				
nsit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	,		,							
'60, be execute sician and burial-tran	хаі	that initiated events resulting in death) Last	c Due to (or as	s a consec	quence of):							
760 b be e												
X 68760, certificate be executed ding physician and itse as the burial-transities.	/Medicai		0.									
		IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome	e of pregn	ancy					23d	. Date of delive	201
Division of Vital Records, P.O. Box or Attending Physician: The law requires that the death certifier death. Director: After this certificate has been signed by the attendin in by the funeral director, page 2 should be detached for use	by Physiciar	in the past 12 months?	1□Live birth 4□Pregnant a			☐ Ectopic pregnand ☐ Other (specify) _	у			250.		Day Year
P.O. hat the did by the detached	ıγsi	9 Unknown	9□ Unknown									
— E DW	y PI	Part II. Other significant conditions	contributing to death	but not res	sulting in the	underlying cause gr	ven in Part I	l.	23e. Did t	obacco use o	contribute to th	ne cause of death?
Division of Vital Records, I or Attending Physician: The law requires tatter death. Director: After this certificate has been signed in by the funeral director, page 2 should be									1 🗆 '	Yes 2 XN	o 3 Prob	ably 4 Unknown
Cord w requir been si	Completed								24a. Was	70	4b. Wara autou	nov findings everlable
I Re The lar	m								autor	osy rmed?	prior to con death?	psy findings available apletion of cause of
Vital F ilcian: Th certificate	e Cc	25. Was case referred to medical							1 Tyes	2 No		2 No
f Vita ysician: is certific	m	examiner? . s	Hospital:		1500	-7 Ot			Check only o			
Of Phys	.: To	1 ☐ Yes 2 No 27. Manner of Death	28a. Date of Ini		ER/Outpation 28b. Time	ant 3E DOA	4 🗆 N			dence 6 🗍	Other (Specify)
On ding h. After funer	tior	1 Natural 5 ☐ Pending	28a. Date of Inj (Month, Da	ay Year)	Injury	Wo	rk?]Yes 2.∐		u. Describe i	iow injury oc	Carred	
isio Mtendi death. ctor: A y the fu	fica	3 Suicide 6 Could not I	De Diago of In	niury - At h	nome farm s	treet, factory, office			Location /	Street and No	umber or Rum	l Route Number,
Divisic of or Attence after death I Diractor:	Certification:	4 Homicide determined	building, e	tc. (Speci	fy)	inot, ractory, onlos			City or Tov	vn, State)	ander or Hular	Houte Number,
Hospitel Hospitel La hours a Funaral I		29a. Certifier 1X Certifying P	hysician: To the best	of my kno	owledge, dea	th occurred at the ti	ime date an	nd place, and	d due to the	rauso(s) and	mannar as et	atod
• Ho 24 h a Fui	Medical	(Check only 2 Medical Exa	miner: On the basis of and manner s	of examina	ation and/or	nvestigation, in my	opinion, dea	th occurred	at the time,	date and place	ce, and due to	the cause(s)
Divi	Me	29b. Signature and title of certifier				29c. Licens	se number			29d. Date sig	gned (Month, L	Day, Year)
		> MKU F	a V	NUK	UGU	Res	M	~		11/16/	ΛÍ	
0		30. Name and address of person)		 ш 23a) (Туре	Print)			1000			
in		Dr Adakii On	tonu 9	mo	Err.	Alin S	Gira i	2	1110	Ba 11	Mrs. 1.4	MD 21337
Sta	te	31. Date filed (Month, Day, Year) NOV 2 2 2 2	32 egist	rar's Signa	atute	had i	July !!	- U C	100	DUIT.	imple	VIV 8133/
Registr	- 91	NOV 2 2 2	UU4 JOSE	W .	N A							

			1 - For State Registrar	State of Ma	ryland	Cer	irtment of F tificate of	lealth and M <i>Death</i>	lental Hyg	ienz 0 0 4	36865
	Physici	an	1. Decedent's Name (First, Middle, Last)						Date of Death Month	Day Year	3. Time of Death
	/Medic	al	Sanjoe Sanchu Au						November	16, 2004	2:16 A. M
	Examin	er	4a. Facility Name (If not institution, give s					r Location of Death		4c. County of Dea	
	Funeral		Holy Cross Hospit 5. Social Security Number 6. Sex		(In yrs. la	st birthday)	Silver S	If Under 24 Hrs.	8. Date of Birth (Month, Day,	Montgome	ery httplace (State or Foreign
	Director		579 - 98 - 7975	M 2□F	85	Yrs.	Months Days	Hours Min.	(Month, Day, Nov. 12		ou <i>ntry)</i> hina
	pug *		Usual Residence of Decedent 10a. State 10b. County		10c City	Town or Lo	cation				10d. Inside City Limits
	Aaryle I sho	o									1X Yes 2 No
	28a-	Directo	Maryland Montgome	ry	511	ver S	pring 10f. Zip Code		10	ng. Citizen of What C	
	3a or		816 Easley Street				20910			nited Sta	
	death	Funeral		12. Was Decedent Ev Armed Forces?	ver in U.S	. 13. V		lispanic Origin? (Spe an, Mexican, Puerto		14. Race - Am	erican Indian,
Maryland 21215-0036	be filed within 72 hours after death with the Maryland Ital Hygiene. d other than "naturel", or Itams 23e or 28e-f show event, it e Modical Examiner must be mailfied at	þ	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 X No If Yes, Give Year or Dates:	0		Tes, specily Cuba	Specify:	nican, etc.)	Specify: As:	
ر ح	72 h	etec	15. Decedent's Edu (Specify only highest grade	cation completed)		16a. Deced	ent's Usual Occup	ation during most of worki	na 1	16b. Kind of Business	/Industry
7	within noe.	Completed	Elementary/Secondary (0-12)	College (1-4or 5+	-)			i)		2 1 1 1 0	
2	filed v Hygie ther i	ပိ	17. Father's Name (First, Middle, Last)	5+	l.	ACCOL	ıntant	18. Mother's Name		British Go Maiden Surname)	vernment
a	m = 0 5	To Be	Ying-Pang Au					Siu-Kuen		,	
a	shou and M s mar umet	-	19a. Informant's Name/Relationship (Ty)	pe, Print)		19b. Mailin	g Address (Street a	and Number or Rura	l Route Number,	City or Town, State,	Zip Code)
Ž	and 2 naith a 127 is		May-May Yee-Yin Au-	-Huie/Daught	er	9728	Sorrel A	venue, Po	tomac, M	aryland 2	0854
ore	of He of He If item or oth		20a. Method of Disposition 1 ☐ Burial 2 TCremation 3 ☐ B	emoval from State	20b. Pla	co of Dieno	sition (Name of natory or other place Y			0c. Location - City or	
Ě	Pag Iment Ient: jury c		1 ☐ Burial 2 ▼Cremation 3 ☐ R 1 ☐ Donation 5 ☐ Other (Specify)		Cre	mator	īum, Inc.	. 2004	В	ethesda,	Maryland
Baltimore,	permit. Pages 1 and 2 should be Department of Health and Menta Importent: If item 27 is marked any Injury or other treumetic express.		21. Signature) of Funeral Service License		1353	Be Be	Name and Address thesda-Cl thesda, N	ss of Facility ROD 6 hevy Chase Maryland	ert A. P. 20814-35	unphrey Fi 7557 Wisco 01	neral Home/ onsin Avenue
			23a. Part1. Enter the disease, or compli shock, or heart failure. List only or	cations that caused the cause on each line	he death.						Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Ventricu	ılar	Fibri	llation				Onset and Death Sudden
	/Medical Examiner		resulting in death)	Due to (or as a	conseque	ence of):					
		7	Sequentially list conditions,	Due to (or as a	conseque	ence of)-					
	ned Insit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	20010 (07.002	001100401						
<u>_</u>	execun and ial-tra	Exa	that initiated events cresulting in death) Last	Due to (or as a	conseque	ence of):					
09/89	icate be executed physician and s the burial-transit	edicai		J							
	- D 4		IF FEMALE:								
X Q Q	eath cert attending for use a	ian/l	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of 1 ☐ Live birth 2	Fetal	death 3	Ectopic pregnancy			23d. Date of de Month	livery Day Year
	at the de by the a tached f	Physician/M	1 Yes 2 No	4☐Pregnant at ti 9☐ Unknown	me of dea	ath 5∐	Other (specify)				54,
<u>ب</u>	that the bear the by detail	y Ph	Part II. Other significant conditions con	tributing to death but	not result	ting in the un	derlying cause give	en in Part I.	23e. Did toba	acco use contribute to	o the cause of death?
coras,	law requires that as been signed b 2 should be deta	ed by	Bladder Cancer						1 🗆 Yes	s 2 □ No 3 □ P	robably 4 X Unknown
ဝပ္ပ	law re as bee 2 sho	Completed	Dehydration						24a. Was an		utopsy findings available
r	9 7 9	mo:	Malnutrition						autopsy perform 1 Yes 2	ed? death?	completion of cause of
VITA	sicien: Th certificate irector, pag	Be	25. Was case referred to medical					26. Place of Death			
	dis y	2	1 ☐ Yes 2 📉 No	ospital: 1 Inpatient		R/Outpatient		4 Nursing Hon		nce 6 Other (Spe	city)
ב	Ilng F After funera	ion:	27. Manner of Death 1 X Natural 5 ☐ Pending	28a. Date of Injury (Month, Day	Year) 2	28b. Time of Injury	28c. Injury Work	/ at 2 <br Yes 2 □ No	8d. Describe how	v injury occurred	
UIVISION	Attendest deat ctor: y the	fical	2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place of Injury	v - At hom	ne, farm, stre			8f. Location (Stre	eet and Number or R	ural Route Number.
2	al or / after Dire	Certification:	4 Homicide determined	building, etc.	(Specify)				City or Town,	State)	and model manager,
	he Hospital or Attending Ph in 24 hours after death. ha Funeral Director: After th pletely filled in by the funeral	Medical C	29a. Certifier 1 Certifying Phys (Check only one) 2 Medical Examin	sician: To the best of ter: On the basis of e and manner state	examinatio	ledge, death on and/or inv	occurred at the timestigation, in my op	ne, date and place, a pinion, death occurre	and due to the cau	use(s) and manner as te and place, and due	s stated. e to the cause(s)
	To the within 2. To the complet	Me	29b. Signature and title of certifier				29c. License	number -	29	d. Date signed (Mont	h, Day, Year)
1			> Johnson	Mo			D 323	32	No	vember 16	, 2004
1	2		30. Name and address of person who co	mpleted cause of dea	ath (Item 2	23a) (Type, F	Print)				
1			Suresh K. Gupta, M	.D., 9801	Geor				Spring	MD. 2090)2
l a	Sta Registr		31. Date filed (Month, Day, Year) NOV 2 2 2	32. Registrar	s signatu		Span	la)			

			State Registrar	ite of Maryland	/ Depa		lealth and I	-		_	368	66
			Hegistrar Decedent's Name (First, Middle, Last)			timouto or		2. Date of Dea	th		3. Time of	
1	Physici		Patrici	a A. Algei	r			Novembe	r 14	Year 2004	6:00	РΜ
	/Medic Examin		4a. Facility Name (If not institution, give street		-	4b. City, Town, o	r Location of Deatl			County of Death	10.00	
1	Cxamin		14335 Georgia Avenue	, #301		Silver	Spring		Mo	ntgomer	У	
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. las	t birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day	Year)	9. Birth	place (State or	r Foreign
	Director		578-64-9044 ^{1□ M 2}	XF 57	Yrs.	WOTHIS Days	Tiodis Will.	November	5, 19	947 Wash	ington	, D.C.
	D		Usual Residence of Decedent 10a. State 10b. County	10c City	Town or Lo	cation					10d. Inside Cit	h. Limite
	sho	5									1 ☐ Yes	
	the N	ect	Maryland Montgomery 10e. Street and Number	51.	iver	Spring 10f. Zip Code			On Citiz	zen of What Cou	ntry?	
	a or	ă	14335 Georgia Avenue	#301		2090	16		•	ed Stat	•	
	death with the Maryland ma 23a or 28a-f show rmust be notified at	Funeral Director		s Decedent Ever in U.S. ned Forces?	13. \	Was Decedent of H				4. Race - Ameri	can Indian,	
0	r iter	E	1 Never Married 2 Married 1 [Yes 2 X No				o Rican, etc.)		Black, White,		
<u> </u>	hours after turel', or ite al Examine	by	3 ☐ Widowed 4 ☐ Divorced Ye	es, Give ar or Dates:		I□Yes 2XINo	Specify:			Specity: Whi	Lte	
2	72 ho	Completed	15. Decedent's Education (Specify only highest grade comp	oleted)	16a. Deced	ient's Usual Occup kind of work done OO NOT use retired	ation during most of wor	tking	16b. Kir	nd of Business/in	dustry	
2	nen hen	ldm	Elementary/Secondary (0-12) Co	ilege (1-4or 5+)			d) -		Dio	netics		
2	be filed within 72 hours after death with the Marylan del Hygiene. del	ပိ	10 17. Father's Name (First, Middle, Last)		Aio	1e	18 Mother's Nan	ne (First, Middle, i				
aŭ	77 C 0 (1	Be c	Leonard Alger					t France				
Maryland 21215-0036	2 should and Men is marke aumatic	ြ	19a. Informant's Name/Relationship (Type, Pri	int)	19b. Mailir	g Address (Street					Code)	
	ss 1 and 2 should of Health and Me Item 27 is mark cother traumation		Michael H. Cox / Fri			Hallet St			-			
ē,	s 1 and 2 f Health item 27		20a. Method of Disposition	20b. Plac		sition (Name of natory or other place				cation - City or To		
Baltimore,	permit. Pages Department of I Important: If Its eny injury or o		1 ☐ Burial 2 🕅 Cremation 3 ☐ Removal 4 ☐ Donation 5 ☐ Other (Specify)	II from State		Crematorium	110 101		Beth	esda, Ma	arvland	}
ati	permit. Departm Importa eny inju	H	21. Signatur of Funeral Service Licensee	1	22	. Name and Addre	ss of Facility					
n	8 9 E 8 8		Injefatte Carri	M01305	$\frac{5}{30}$	bert A. Pu O West Mon	mpnrey fun itgomery Av	eral Home/I enue, Rock	Kockv Ville	ille, Inc e, Maryla	nd 20850	-2805
			23a. Part1. Exer the disease, or complication shock, or heart failure. List only one cau	s that caused the death. se on each line.							Approximate Interval Betw	veen
7	Physician		Immediate Cause (Final disease or condition	herasclerot	7 C	cardiova	ascular	disea.	se		Onset and D	eath
	/Medical Examiner		resulting in death)	Oue to (or as a consequent								
	Д ХСПППСТ	J.	Sequentially list conditions, b.	Dentensial								
	nsit	nine	cause. Enter Underlying Cause (Disease or injury	pe to (or as a consequen	100 (1).							
	s be executed sician and burial-transit	Examiner	that initiated events	Oue to (or as a consequer	nce of):							
/60		call	U _d									
9												
Rox	th cer endir r use	M/ne	23b. was decedent pregnant	es, outcome of pregnanc Live birth 2 ☐ Fetal de		Ectopic pregnancy	,		2	3d. Date of delive	,	
	ed for	sicia	in the past 12 months? 1 ☐ Yes 2 ☒ No	Pregnant at time of deat		Other (specify)	·			Month	Day Y	ear
J.	at the	Physician/Med	9 Unknown					00- 0:4				
	The law requires that the death certifical te has been signed by the attending phyage 2 should be detached for use as the	by	Part II. Other significant conditions contribution	ng to death but not resulti	ng in the ur	iderlying cause giv	en in Part I.			se contribute to ti]No 3 ☐ Prot		
Records,	requi	eted						1	35 2	1140 3 FIOL	Jably 4 Jacol	RIIOWII
ေင	elaw hasb je 2 si	omple						24a. Was a autops	y	24b. Were auto prior to co death?	psy findings a mpletion of ca	vailable use of
		0						perform 1 Yes 2	No.	1 Yes	2 NO	
Vital	sicien: The la certificate ha irector, page 2	Be	25. Was case referred to medical examiner?			Oth	00	th (Check only on			-	
ō	Phys r this ral di	. To	I)STOS 20 NO	1 Inpatient 2 EF	∛Outpatien 3b. Time of	I 3 DOA	4 🗆 Nutsing 🗆	ome 5 Reside			y)	
Division of	ding F th. : After i	tlon	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	. Date of Injury (Month, Day Year)	Injury	28c. Injun Worl M 1	k? Yes 2 □No		,,			
S	il or Attending Physicien: after death. Director: After this certific 3 in by the funeral director,	ifica	3 Suicide 6 Could not be 28e	. Place of Injury - At home	e, farm, str	eet, factory, office		28f. Location (St	reet and	Number or Rura	I Route Numb	er,
ă		Certification:	4 Homicide	building, etc. (Specify)				City or Town	i, Siaie)			
	To the Hospitel within 24 hours a To the Funeral completely filled		29a. Certifier (Check only 2 Medical Examiner: 0									
	To the h within 24 To the F complete	Medical	one) ar	d manner stated.								
	or veit	-	29b. Signature and title of certifier	p. m.	Lu. A	29c. Licens	5/9/6	2	od. Date	signed (Month,	Day, Year)	24
,			Vatucia lons		IND		. , , , , ,		VUUt	mper 1	1) 200	7
r)		30. Name and address of person who complete	cause of death Itemy 2	sa) (Type,	Dike 6	51916 3-100, X	ockville	2, 1	MD 20	1852	
Š	Sta	te	31. Date filed (Month_Day, Year)	32. Register's Signatur	9	111010	, , , ,	-1111				
	Registr		NOV 2 2 2004	General	1							

ORIGINAL

			For Amend Item 20aState of Management 1-State Ce	ஹ் ரு ச்சுந்தூ Health and N ertificate of Death	ental Hygie/ _{.Reg.}	2004	36867
	Physici	an	1. Decedent's Name (First, Middle, Last) Brenda Ida Harris Brown		2. Date of Death Month	Day Year	3. Time of Death
	/Medic Examir		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	Nov. 15	, 2004 4c. County of Death	6:00P.M
			3602 Oakmont Ave	Baltimore		N/A	
	Funeral Director		5. Social Security Number 6. Sex $1 \square M$ $2 \not \bowtie F$ 7. Age (In yrs. last birthday) 1. Usual Residence of Decedent	Months Days Hours Min.	8. Date of Birth (Month, Day, Ye Sept. 24	9. Birthpi Coun 4,1954 Ma	eryland
	aryland show		10a. State 10b. County 10c. City, Town or L			1	0d. Inside City Limits
	he Ma	Director	Maryland N/A Balti				XXYes 2 □ No
	ath with t		10e. Street and Number 3602 Oakmont Avenue	10f. Zip Code 21 21 5		Citizen of What Coun JSA	try?
980	s within 72 hours after death with the Maryland liene. r then "naturel", or tems 23a or 28e-f show the Medical Evania writhust be inclified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes, Give Year or Dates:	Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 ▼ No Specify:	ecify Yes or No- Rican, etc.)	14. Race - America Black, White, e	etc.
5-0	72 hc "natur	etec	(Specify only highest grade completed) (Give	edent's Usual Occupation e kind of work done during most of work	ing	. Kind of Business/Ind	
21215-0036	filed within Hygiene.	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	al Assistant	Ma	iryland D	Dental Lab
land 2	be filed stal Hyg od othe event,	To Be C	17. Father's Name (First, Middle, Last) Joseph Harris		e (First, Middle, Maid	den Sumame)	
, Maryland	d 2 shoth and the and the modern treum			ing Address (Street and Number or Rur Oakmont Avenue			
Baltimore,				osition (Name of amatory or other place) 11/2 ount Cemetery	20/04	Location - City or Too ltimore,	wn, State Maryland
Balti	perrit. Pages Department of Importent: If i any injury or once.			2. Name and Address of Facchat 240 Reisterstow			
	Physician		23a. Part 1. Enter the disease, or complications that caused the death. Do not en chock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition				Approximate Interval Between Onset and Death
	/Medical Examiner		Due to (or as a consequence of):	mellitus ty	100 2	И	years
	led sit	niner	Sequentially list conditions, if any, leading to immodulate cause. Enter Underlying Cause (Disease or injury that leating dependence)	1	<i>*</i>		
68760,	ificate be executed g physician and as the burial-transit	cai Examin	that initiated events consequence of): Due to (or as a consequence of):				
		Medicai	IF FEMALE:				.,1
.O. Box	at the death cert by the attendin tached for use	Physician/M	23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 [□Ectopic pregnancy □ Other (specify)		23d. Date of deliver Month	ry Day Year
9	uires that t signed by Id be detai	by	Part II. Other significant conditions contributing to death but not resulting in the u	underlying cause given in Part I.	23e. Did tobacc	co use contribute to the	e cause of death?
Division of Vital Records,	The law requires that the death cerrate has been signed by the attendin page 2 should be detached for use	Completed			24a. Was an autopsy performed	prior to com death?	nsy findings available inpletion of cause of
Vita	Physicien: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner? Hospital:	Out .	(Check only one)		
of	Phys r this ral dir	J: To	27. Manner of Death 28a. Date of Injury 28b. Time o	of 28c. Injury at	me 5 Residence 28d. Describe how in	6 Other (Specify)	
ision	l or Attending Fatter death. Director: After in by the funer.	Certification:	1 🗷 Natural 5 Dending (Month, Day Year) Injury 2 Daccident Investigation 3 Duicide 6 Double not be 28e. Place of Injury - At home, farm str	Work? M 1 Tes 2 No		and Number or Rural	Route Number
Ď	the Hospitel or At in 24 hours after of the Funeral Direct pletely filled in by		4 ☐ Homicide building, etc. (Specify) 29a. Certifier 1⊠ Certifying Physicien: To the best of my knowledge, death		City or Town, St	ate)	
	To the Hos within 24 h To the Fur	Medicai	(Check only one) 2 Medical Examiner: On the basis of examination and/or in and manner stated. 29b. Signature and title of certifier	ivestigation, in my opinion, death occurr	ed at the time, date a	and place, and due to t	the cause(s)
)			Brewa 1311_ M.	D. DOOG171	5	11 18	2004
Y	1		30. Name and address of person who completed cause of death (Item 23a) (Type, Brendan Bellew 2435	Print) West Belveder	e Aveni	re Balti	more MD
	Sta Registr		NOV 2 2 2004	gover!			

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** Burney 2335 Lanvence 15 2004 November /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** esex/ otral 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 5. Social Security Number (In yrs. last birthday) **Funeral** Months Days Hours Min 1 M 2□ F 227.42.8736 Yrs. Director Usual Residence of Decedent 10a. State 10b. County 10c. Only, Town or Location Item 27 is marked other than "natural", or Items 23a or 28a-1 show other traumatic event, the Medical Example river must be notified at 1 Yes 2 No Be Completed by Funeral Director 10g. Citizen of What Country? 10e. Street and Number Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status orces? Yes 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 ☐ Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Pages 1 and 2 should be in ment of Health and Mental ant: If Item 27 le marked o Method of Disposition permit. Pages Department of I Important: If It any injury or o Burial 2 Cremation 11-23-04 CHINGS MILLS, MARYCAND * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility VAVEHN C. GREENE FUNERIR HOME 21. Signature of Funeral Service Licenses ROAD BALTIMORE, MARYLAND 21212 23a. Part1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Cardiogenic **Physician** SMOCK 5 days disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** 7 days miocarditis Sequentially list conditions, it any sample to mindral cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner The law requires that the death certificate be executed cale has been signed by the attending physicien and page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Yes 2 No 3 Probably 4 Unknown Hypentension 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Diabetcs mellitus autopsy this certificale 2 🗓 No 1 Yes or Attanding Physician: filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 No Certification: To 1 Unpatient 2 ER/Outpatient 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 317 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. 28d. Describe how injury occurred After 1 Natural 2 Accident Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Eckert, MD Res- 000 November 15 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 600 North Wolfe Street Lynn Eckert, MD Junes Hopkins Hospital Baltimore, MD 21287 31. Date filed (Month, Day, Year) 32. Registrar's Signature Registrar

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2004 Certificate of Death 2. Dete of Deeth 1. Decedent's Name (First, Middle, Last) Month Dey Year **Physician** Burton 8:50 PM arqueritee. mber 19 .2004 /Medical 4a Fecility Negra (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner salfimore nome 122685 omwel If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Dey, Yeer) 5. Social Security Number Age (In yrs. lest birthday) Birthplace (State or Foreign Country) **Funeral** Months Deys Hours 1 □ M 20 F Director 914-19-4848 JARYLA Usuel Residence of Decedent filed within 72 hours efter death with the Marylend 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "naturel", or frams 23a or 28a-f show treumetic event, the Medical Examiner must be notified at 1 ☐ Yes 21 No Funeral Director DARJARO BALTIMORE 10g. Citizen of What Country? 10f. Zip Code 10e, Street end Number 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 9523 .8 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black. White, etc. 1 ☐ Yes 25 No If Yes, Give Year or Dates: 1 ☐ Never Married 25 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify. Specify: (Completed by 3 ☐ Widowed 4 ☐ Divorced WHITE 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry is marked other than Elementery/Secondary (0-12) College (1-4or 5+) GLINL. MARTIN ASOMBLER HYRS. permit. Pages 1 and 2 should be file.
Department of Health and Mentel Hyg
important: If item 27 is marked other
any injury or other treument 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be BROMLEY Anorew SIZANOR 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Reletionship (Type, Print) 20c. Location - City or Town, State ERVIN W-BURTOR BURTONAY TAR 1ARTLANC 9533 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date Nov. 20 1 ☐ Burial 2 Cremation 3 ☐ Removal from State lest/sec 4 ☐ Donation 5 ☐ Other (Specify) 200H FORJST HILL 22. Name and Address of Facility 21. Signatur of Funeral Service Licensee 10Ris ISARH 2 ZOAV3 983H 8800 HARFORD YOAD 1221/200 23a. Part1. Enter the disease, or complications that ceused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heert tailure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final diseese or condition resulting in death) /Medical 12548 Examiner Due to (or es a consequence of) Physician/Medical Examiner or Attending Physician: The lew requiras thet tha death certificeta be executed Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Lest Due to (or es a consequence of) Division of Vital Records, P.O. Box 68760. Due to (or es e consequence of) Part II. Other eignificent conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobecco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown þ 24b. Were autopsy findings available prior to completion of cause of death? cate has been significant began 2 should be Completed 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 1 Yes 20 No after death.

Director: After this certification in by the funerel director. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 28e. Date of Injury (Month, Dey Year) 28c. Injury at Work? 27. Menner of Deeth 28b. Time of 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Naturel 1 Yes 2 🗆 No 2 Accident 3 Suicide 6 Could not be determined 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rurel Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a To the Funeral D completaly filled Hospital edical 29a. Certifier 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the ceuse(s) and manner es stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature end title of certifier 30. Name end address of person who completed cause of deeth (Item 23e) (Type, Print) 560 jac 31. Date filed (Month, Day, Yeer) 32. Registrer's Signeture State Registrar

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			State of Maryland	/ Depa		lealth and	Mental Hyg	20	Ul 3	6070
			Registrar	Cei	inicate of i	Dealii	2. Date of Dea	leg. No. 🚣 🔾	3. Tir	ne of Death
1	Physicia	าก	1. Decedent's Name (First, Middle, Last)				Month	Day	Year	J. H. Col. W
	/Medic		MARGARET ANNE BRO	Me I	4b. City, Town, or	r Location of De	111111111111111111111111111111111111111	4c. County	100	0.
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			5. Social Security Number 6. Sex 7. Age (In yrs. last	t birthday)	If Under 1 Year	If Under 24 H	rs. 8. Date of Birth		9 Birtholace (St.	ate or Foreign
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	3e ol		2502 MUNSTER ROAD		2183	L		2.(1	. A.	
	ms 2	by Funeral Director	11 Marital Status 12. Was Decedent Ever in U.S.	13.	7-4		(Specify Yes or No- erto Rican, etc.)	14. Race	e - American India	an,
(0	riter or liter	F	Amed Forces? 1 □ Never Married 2 □ Married 1 □ Yes 2 ☑ No		1 Tes, specify Cuba 1 ☐ Yes 21% No	Specify:	erto riicari, etc.)			
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7	filed with Hygiene. other ther	5	13782 4785	()	URU			MEAL!	H TURS	
힏	be filed ntal Hygi of other event.	Be (17. Father's Name (First, Middle, Last)			18. Mother's N	lame (First, Middle,		Θ)	
<u> a</u>	should b ind Ments marked umetic e	Tof	CHARLE R. JACKSON					KLAIR		
Maryland	2 sho and le ma		19a. Informant's Name/Relationship (Type, Print)	19b. Mailir	ng Address (Street	and Number or	Rural Route Numbe	r, City or Town,	State, Zip Code)	,
	and 2 palth n 27		5.44	1012	LARLIS	EHVI	· HEBSIH	ETT 1.15	1841700	21336
J.C	of He item		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State	ce of Dispo netery, crer	sition (Name of natory or other place	(8)	Date V - 22	20c. Location -	City or Town, Sta	te
Ē	iit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan perment of Health and Mental Hygiene. crient: If item 27 is marked other then "netural; or Items 23e or 28e-1 show injury or other treumetic event. It is Mydical Examinat must be notified at a	1 8	*4 Donation 5 Other (Specify)	VK3)	MEN YELLIS		2004	Timori	Um MAY	CHALKS
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ä	Deprini Departiment any r		The throat		8800 HE		ROSO PAY	3/4/11/2	MARYLA	20
			23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line.	Do not ent	er the mode of dyir	ng, such as card	liac or respiratory are	rest,	Approx	I Between
	Distriction .		Immediate Cause (Final	- S	Edanne				Onset	and Death
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	Examiner		(and invite	110 Da	Thu				101	ears
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Вох	nding use g	M	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnanc		75			23d. Dat	te of delivery	
ă	death atte	cia	in the past 12 months? 1 Vos 2 Volo 4 Pregnant at time of deat]Ectopic pregnancy] Other (specify) _			Moi	nth Day	Year
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ds.	uires signa lid be						1□Y	es 2□No	3 Probably	4 Unknown
2	w require been sig should b	ompleted					24a. Was	an 24b. V	Were autopsy find	lings available
Re	The lav ate has page 2	ם					autop perfor	rmed?	prior to completion death? I Yes 2 No	
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V.		Be	25. Was case referred to medical examiner? 1 Tyes 2 Tylo Hospital: 1 Inpatient 2 F	R/Outpatier	oth	or	g Home 5 Resid		et (Specify)	
of	Phye this ral di	Ţ	27 Manner of Death 28a, Date of Injury 2	8b. Time o	f 28c. Injur	y at	28d. Describe h			
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Division	of or Attending Patter death. I Director: After I din by the funers	Certification;	4 Homicide determined building, etc. (Specify)	, , , , , , , , , , , , , , , , , , , ,			City or Tow	m, State)		
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	Hos 24 hc Fun Fun	edical	(Check only one) 2 Medical Exeminer: On the basis of examination and manner stated.	n and/or in	vestigation, in my o	ppinion, death o	ccurred at the time,	date and place, a	and due to the car	use(s)
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	10		30. Name and address of person who completed cause of death (Item 2	1 јуре,	10755	FAIK	Rd Lu	thervi,	The Mel	. A6/3
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	/Medic	al.		ruce Norwo	ood Beas	тел		1 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7			15,2004	3:15 AM
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			Stella Maris Hosp 5. Social Security Number 6. S		e (In yrs. last birl	thdav)	TOWSO	If Under 24 Hrs	8. Date of Bir	rth	Baltimo	ore Co.
	Funeral Director		218-28-4062	M 2□F		Yrs.	Months Days	Hours Min.		ay, Year)		nplace (State or Foreign unity) aryland
	iryland show	_	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	n or Lo	cation		<u> </u>			10d. Inside City Limits
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	th with the 23a or 2		10e. Street and Number 2520 Lodge Fore	est Drive			10f. Zip Code	21219		-	izen of What Co ited Sta	
215-0036	be filed within 72 hours after death with the Maryland ital Hygiene. Id other than "natural", or items 23a or 28a-f show other than "natural", or items 23a or 28a-f show avent, the Medical Evander mind the notified at	by Funeral	11. Marital Status 1 Never Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates:			Vas Decedent of H iYes, specify Cuba I□Yes 2☑No	lispanic Origin? (S an, Mexican, Puer Specify:	Specify Yes or No to Rican, etc.))·	14. Race - Ame Black, White Specify:	
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2	should be nd Mental marked o umatic eve	ဥ	John Beasley 19a. Informant's Name/Relationship (1)	Suma Print)	10h	Mailia	g Address (Street		se Carrio		Town Chair 7	in Code)
Maryland 21	d 2 sho th and 7 is mu trauma		Mrs. Mary S. Be		· ·) Lodge F				re, MD	21219
	is 1 and 2 should of Health and Mer Item 27 is marke other traumatic	1	20a. Method of Disposition	abicy/ mil	_		sition (Name of natory or other place		Date		ocation - City or	
<u>o</u>			1 Burial 2 Cremation 3 Donation 5 Other (Specify					!	/10/000			
Baltimore,	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service Licen		00	22	Service Name and Address	ss of Facility			-	Maryland
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-	Physician /Medical		231. Pmf1. Enter the disease, or compshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	one cause on each ling	10.		er the mode of dyin	ig, such as cardia	c or respiratory a	rrest,		Approximate Interval Between Onset and Death
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	sit ad	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Orinius		a consequence of	of):						
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O. Box	The law requires that the death certifi te has been signed by the attending age 2 should be detached for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal death		Ectopic pregnancy Other (specify)	,		1	23d. Date of deli Month	very Day Year
<u> </u>	res lhat l igned by be deta		Part II. Other significant conditions of	ontributing to death b	ut not resulting in	the ur	iderlying cause giv	en in Part I.	23e. Did t	obacco u	ise contribute to	the cause of death?
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ō	Phys r this ral di	-: To	1 ☐ Yes 2 🔀 No 27. Manner of Death	1 L Inpatre	nt 2 ER/Ou	tpatient	3 DUA	4 U Nursing F	lome 5 ∐ Resident			HOSPICE
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Division of	Hospital or Attending Physician: 44 hours after death, Funeral Director: After this certific tely filled in by the funeral director,	Certification:	3 Suicide 6 Could not be determined		ury - At home, fai c. (Specify)	rm, stre	eet, factory, office		28f. Location (S City or Tox			al Route Number,
	To the Hospital or vithin 24 hours after To the Funeral Direction completely filled in b	edical C	29a. Certifier (Check ont one) 1 X Certifying Ph	vsician: To the best of the basis of and manner sta	examination and	, death d/or inv	occurred at the tin restigation, in my o	ne, date and place pinion, death occu	a, and due to the urred at the time,	cause(s) date and	and manner as I place, and due	stated. to the cause(s)
	To th within To th	Me	29b. Signature and title of certifier				29c. License	e number		29d. Dat	e signed (Month	Day, Year)
•							D	4772	7	,	11/151	104
	10		30. Name and address of person who	completed cause of d	eath (Item 23a) (Туре, і	Print)	1012			1 -1	
-	3		DR. TARIQ MAHMO		ULANEY	VAL	LEY RD.	TIMONIUN	4, MD 21	093		
	Sta		31. Date filed (Month, Day, Year)	N/	ar's Signature	1	1					
DU	Registr		NOV 2 2 2	004 50	pera	M	Sport	2/				
אוויט	VIH 17 Rev 1/2	JUI					•					

ORIGINAL

			1 - For Stata Registrar	State of M	aryland		rtment of H		nd Mei		\sim	04	36972
		п	Decedent's Name (First, Middle, La.	st)					2.	Date of Death			3. Time of Death
	Physici /Medio		Stephen	H. Bei	-tsc	h				Month i	Day	Year O'4	1025AM
	Examir		4a. Facility Name (If not institution, give	e street and number)			4b. City, Town, o	Location of E	Death		4c. County	of Death	
		•	Baltimore Rehibilitat					t.max					
-10	Funeral Director		5. Social Security Number 6. S 220-54-7842	ex 7. Ag	ge (In yrs. Ia: 55	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hours	Min. C	Date of Birth (Month, Day,) Oct 30,	(ear) 1949	Cour	place (State or Foreign otry) yland
			Usual Residence of Decedent							, cc 50 ,	1777	mai	yrand
	nyland how		10a. State 10b. County		10c. City,	Town or Loc						1	0d. Inside City Limits
	Ba-1 s	Director	MD Balti	more		Tows	son						1 □ Yes 2√ No
	or 2	Dire	10e. Street and Number	_			10f. Zip Code			109	g. Citizen of V	What Cour	itry?
	s 238	ra	1645 Mussula Roa		Free is II C	40.11	2128		0 (0:	. Van an Na	USA		can Indian,
36	72 hours after death with the Maryland naturel', or items 23a or 28a-1 show dical Examinat must be rodified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces 1 X Yes 2 1 If Yes, Give Year or Dates:	?		Vas Decedent of H Yes, specify Cuba	Ispanic Origin an, Mexican, F Specify:	1? (Specif Puerto Ric	y Yes or No- an, etc.)	Blac	ck, White,	etc.
21215-0036	72 hours naturel', ileal Ext		15. Decedent's Ed			16a. Deced	ent's Usual Occup	ation	6 - dila-	16	6b. Kind of B	usiness/In	dustry
215	- 100	Completed	(Specify only highest gra	College (1-4or	5+)	life. D	kind of work done OO NOT use retired	during most o d)	r working				
21	be filed within 72 ho stal Hygiene. Id other than "natu event, ILe Medical	Con	12	2			disabl				nor		
Maryland	should be filed within and Mental Hygiene. marked other than matic event, II.e M.	Be	17. Father's Name (First, Middle, Last) Herbert Consal		h					First, Middle, Ma		10)	
Ĕ	2 should be i and Mental I is marked or reumatic eve	2	19a. Informant's Name/Relationship (19h Mailin	g Address (Street			e Cunni		State Zin	Code
∑	3 2 3		Cynthia L. Berts				Mussula				21286	Oldio, sop	, 0000)
<u>6</u>	s 1 and 2 f Health Item 27 other tre		20a. Method of Disposition	cn/spouse	20b. Pla	ce of Dispos	riussula sition (Name of natory or other plac		Date		Oc. Location -	City or To	own, State
E O	Page: ient o nt: If		1 ☐ Burial 2 ☐ Cremation 3 ☐ 3 ☐ Other (Specific) cer	петегу, степ	ratory or other prac	(8)					
Baltimore,	permit. Pages 1 Department of H Importent: If Ite any injury or ot once.		21. Signal re of Financial Solvice Licer Ronald S.	Wado, Dir	ector	Şt	Name and Addre	omy Bo	ard.	655 W.	Baltim	ore S	Street
			23a. Part1. Enter the disease, or com	plications that cause	d the death.		Itimore, ar the mode of dyin		rdiac or n	espiratory arres	st,		Approximate Interval Between
	Physician /Medical Examiner		shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)		testic	Cone	er of u	ملامه	32	prime	-6		Onset and Death
п	Examiner	L	Sequentially list conditions,	b							- 98		
	led	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a conseque	ince of):							
	cate be executed physician and the burial-transit	xan	that initiated events resulting in death) Last	c. Due to (or as	a conseque	ence of);						-	
38760,	e be siciar	dicai		d									
.89	ifficat g phy as th	ledi											
O. Box	that the death certific ed by the attending p detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant a 9 □ Unknown	2 Fetal c	teath 3□	Ectopic pregnancy Other (specify)	′				te of delive	ery Day Year
s, D	s that ned b	by PI	Part II. Other significant conditions of	ontributing to death t	out not result	ting in the un	iderlying cause giv	en in Part I.		23e. Did toba	acco use cont	tribute to t	he cause of death?
rds	v requires been sign should be		Human In	manodefi	crenez	_ Vir	ns			1 ☐ Yes	2 □ No	3 ☐ Prot	Dably 4 Unknown
Record	he lav e has age 2	Completed							_	24a. Was an autopsy perform	ed?	prior to co death?	opsy findings available impletion of cause of
Vital	icien: 1 certificat rector, p	Be (25. Was case referred to medical examiner?					26. Place o	f Death (0	Check only one	,		
of V	S S	2	1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ Inpati		R/Outpatient		Turs		5 🗌 Residen			(y)
		ion:	27. Manner of Death 1 □ Natural 5 □ Pending	28a. Date of Inju (Month, Da	iry Year) 2	8b. Time of Injury	28c. Injur Wor	k?		d. Describe hov	v injury occur	red	
isio	ten leat tor: the	icat	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be		iunt - At hom	o form stre		Yes 2 □ No		Location /Str	eet and Numl	her or Rur	al Route Number,
Division	of or Attendent after death	Certification;	4 Homicide determined	building, e	ic. (Specify)	ie, iailii, stre	et, factory, office		201	City or Town,	State)	307 07 1107	
	To the Hospitel or At within 24 hours after or To the Funerel Direct completely filled in by	edical C		ysicien: To the best niner: On the basis of and manner st	of examination								
	To th withir To th comp	Me	29b. Signature and title of certifier				29c. Licens	e number		29	d. Date signe	d (Month.	Day, Year)
)			1 m Ho	·//	- wi	>	Doo	550	35		11/17	404	•
			30. Name and address of person who		death (Item 2	23a) (Type, i				,		,	
	Sta	10	31. Date filed (Month, Day, Year)		30 + i m		MO ZIZ	18	4	no He	Marin	60	m.D
	Registr		NOV 2 2 2		pera	5	Sport	2					

			For State Registrar	tate of Maryland / [Department of Hocean	lealth and Mo Death	ental Hygier Reg. I	2004	36873
			Decedent's Name (First, Middle, Last)				2. Date of Death Month	Day Year	3. Time of Death
	Physicia /Medic		Baby Boy Brown Twi	n A			Nevember	/ -	1 23:16P M
	Examin		4a. Eacility Name If not institution, give stre		4b. City, Town, or	Location of Death		4c. County of Deat	h
			The Johns Hople	ins Hospital	Balti	mone Ci	ty		
	Funeral		5. Social Security Number 6/Sex	7. Age ∫in yrs. last bir 2□ F	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Yea	9. Birn	hplace (State or Foreign buntry)
	Director		none		Yrs. 4		November	2, 2004	Maryland
	and and		Usual Residence of Decedent 10a. State 10b. County	10c. City, Tow	m or Location				10d. Inside City Limits
	Many fehc	ō	MD	Balt:	imore				1 🛱 Yes 2 🗆 No
	the 28a	Director	10e. Street and Number		10f. Zip Code		10g.	Citizen of What Co	ountry?
	3a or		951 N. Collington	Avenue	2	1205		USA	
	ms 2	Funerai		Was Decedent Ever in U.S.	13. Was Decedent of H		city Yes or No-	14. Race - Ame	
က	after or Itel	Ē	1 X Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 No	1 Yes, specify Cuba	in, mexican, Puerto r Specity:	(ican, etc.)	Black, Whit	
Ö	ral', c	i by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	TES ZALINO	эрөспу.		Specify: }	lack
2	72 h	Completed	15. Decedent's Educat (Specify only highest grade of		. Decedent's Usual Occup (Give kind of work done)	during most of workin	16b.	Kind of Business	Industry
7	ithin nan *	idu	Elementary/Secondary (0-12)	College (1-4or 5+)	life. DO NOT use retired	1)			
7	led w lygier har ti		none non	ne l	none	18. Mother's Name	/First Middle Maid	none	
JUE	be fill he of ot	Be	17. Fattlet's Native (1715), Inidule, Lasty		unk				
Ž	should be filed within 72 hours after death with the Maryland ind Mentle Hygiene. And Mentle Hygiene a marked othar than "natural" or Items 23a or 28a-f show marked othar than "natural" or Items 23a or 28a-f show umatic event. The Medical Examiner must be notified at	2	19a. Informant's Name/Relationship (Type,	Print) 19h	o. Mailing Address (Street		que Brown		Zin Code)
Ma	d 2 si th an 7 is r traur		Johns Hopkins Hosp		00 N. Wolfe				_
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Healin and Mentle Hygiene. Department of Healin and Mentle Hygiene. Department if the maz's is marked othar than "natural; or Items 23a or 28a-1 ehow any injury or othar traumatic event, the Madical Examinal must be notified at once.		20a. Method of Disposition	20b. Place o	of Disposition (Name of	Da		Location - City or	
o D	ages ant of t: If It		1 ☐ Burial 2 ☐ Cremation 3 ☐ Rem '4 ☐ Donation 5 📉 Other (Specify)	loval from State	ry, crematory or other plac	:e)			
Ė	artme ortan injur	1			22. Name and Addre	ss of Facility			
B	Dep Imp any		21. Signature of Funeral Service Licensee	de director	State Anat Baltimore,	omy Board MD 2120		altimore	Street
			23a. Part1 Enter the disease, or complica	ions that caused the death. Do	<u> </u>				Approximate Interval Between
	Physician		shock, or heart failure. List only one Immediate Cause (Final	Dosailation	Distress	Syndra	1000		Onset and Death
	/Medical		disease or condition resulting in death)	Due to or as a consequence		Jyvia c			5 10045
	Examiner		Conventially list conditions b	Se0513					5 001
	D ==	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence		11			5 days
	ecute ind trans	Examiner	Cause (Disease or injury that initiated events c resulting in death) Last	5x treme	Premate	MITY			Jays
90,	The law requires that the death certificate be executed are has been signed by the attending physician and page 2 should be detached for use as the burial-transit		Tosulting in doubly cast	Due to (or as a consequence	or):	(
8760,	cate b	dical	d						
9 ×	that the death certific ed by the attending p detached for use as	/Me	IF FEMALE: 23c	If yes, outcome of pregnancy				23d. Date of de	iven
Вох	atten for u	cian	in the past 12 months?	1 Live birth 2 ☐ Fetal death	n 3 ☐ Ectopic pregnancy 5 ☐ Other (specify)	,		Month	Day Year
O.	y the	ıysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown					
Q	res that igned b be deta	Completed by Physician/Me	Part II. Other significant conditions contri		in the underlying cause giv	en in Part I.	23e. Did tobacc	o use contribute to	the cause of death?
rds	auire; n sign	d b	Metabonic Acu	dB1)			1 Tes	2 No 3 □ P	obably 4 Unknown
CO	aw requir as been si 2 should	olet	Patent duche	arteriose	15		24a. Was an		utopsy findings available completion of cause of
R	The lay te has	mo Umo					autopsy performed 12 Yes 2	? death?	~
<u>a</u>	ysician: The l is certificate ha director, page	a	25. Was case referred to medical			26. Place of Death			
>	Physical this cal	To B	examiner? 1 ☐ Yes 2 No	pital: 1 ★ npatient 2 ☐ ER/O	utpatient 3 DOA Oth	er: 4 Nursing Hom	ne 5 Residence	6 □Other (Spe	cify)
0 _	ng Pl fter th		27. Manner of Death 1 ☑ Natural 5 ☐ Pending		Time of 28c. Injur Injury Wor	k?	8d. Describe how in	jury occurred	
Sio	andii eath. or: A the fu	cati	2 Accident investigation			Yes 2 □No			
Division of Vital Records,	or Att	Certification:	3 Suicide 6 Could not be determined	 Place of Injury - At home, for building, etc. (Specify) 	arm, street, factory, office	2	8f. Location (Street City or Town, St		urai Houte Number,
	urs all		Continue Physics	ings To the heat of the knowledge	an death assumed at the time	data and place o	ad due to the source	/s) and manner as	rtated
	To the Hospital or Attanding Physician: within 24 hours after death. To tha Funaral Director: After this certific completely filled in by the funeral director,	Medical	29a. Certifier \(\sum \) Certifying Physic (Check only one)	ian: To the best of my knowledg : On the basis of examination ar and manner stated.	nd/or investigation, in my o	pinion, death occurre	d at the time, date	and place, and due	to the cause(s)
	Fo thi within Fo thi	Me	29b. Signature and title of certifier		29c. Licens			Date signed (Mont	
	->-0		HOLA	Man M	N RE	5-000) NOV	unber !	11UM, 2004
			30. Name and address of person who com	leted cause of death (Item 23a)	(Type, Print)				
			Hagner Smisen in	10 Johns Hupk	uns Hospira	1 600 N.N	volfe St 1	sulmere	MD 21287
	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Signature	/				
	Registr	ar	NOV 2 2 200	Depera	D Some	/ /			

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend 1tem 1ba per 1h 8837 11-24-04 vt

State of Maryland / Department of Health and Mental Hygiene 1 - For Stete Registrar 004 36874 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 11 13 04 5:40 PM Dr. Robert Spencer Beale Jr. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner University Of Shock Trauma Center Baltimore 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 9. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** Months **™** M 2□ F Prairie View 237-64-9685 Director Usual Residence of Decedent the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a, State 7 is marked other than "natural", or items 23e or 28e-f show traumatic event, the Modical Examinator in this be notified at 1 XYes 2 No Directo Md. Howard Columbia 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 10438 Waterfowl Terrance 21044 filed within 72 hours after death Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. XYes 2 Yes, Give 1 Never Married 2 Married 2 🗌 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Black 3 Widowed 4 Divorced Year or Dates: 16a. Decedent's Usual Occupation
(Give kind of work done during most of working 15. Decedent's Education (Specify only highest grade completed) 16b, Kind of Business/Industry Hygiene. Medical use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 5+ Medicine Doctor Private Practice 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be should be find Mental It and Mental Robert S. Beale Sr. Mabel S. Beale 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 s ment of Health an ant: if itam 27 ts 10438 Waterfowl Terrance, Columbia, Md. 21044 Marilyn T. Beale Wife other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages Department of Important: If it any injury or o 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Christ Cemetery 11-20-04 Columbia Md. 1 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Estep Brothers Funeral Ser, P.A.
1300 Eutaw Place, Baltimore, Md. 21. Signature of Funeral Service Licensee Estep Brothers Funeral S

1300 Eutaw Place, Baltimo

23a. Part. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician 20 disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** tov 10 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner The law requires that the death certificate be executed burial-transit the attending physician and the for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical 200 CERTIFICATION IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 3 Ectopic pregnancy Month Day Year 5 Other (specify) 4 Pregnant at time of death be detached 9 Unknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. by 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 2 No 1 TYes 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) Hospital: Other: 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA Certification: To 4 Nursing Home 5 Residence 6 Other (Specify) this 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred funeral 28b. Time of 27. Manner of Death 28c. Injury at Work? Priver lost Contol and Collided After Attanding 1 Aatural 5 Pending 1 ☐ Yes 2 ☑ No 13/200 death. investigation 2 Accident s after death the 6 Could not be determined

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number. City or Town, State)

28 Location (Street and Number or Rural Route Number. City or Town, State)

28 Location (Street and Number or Rural Route Number. City or Town, State) 6 Could not be determined 3 Suicide filled in by Rd / New 4 | Homicide ö To the Hospitat o within 24 hours aft To the Funaral Dia 6 cm but 29a Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of gertifie 29c. License number 29d. Date signed (Month, Day, Year) AU4176435 1200 M.B 16225 30. Name and address, of person who completed cause of death (Item 23a) (Type, Print) 7m 9 CAN 154

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

ORIGINAL

32. Registrar's Signature

			1 - For State Registrar	State of Mar	yland / Depa <i>Ce</i>	artment of Health rtificate of Deal	h and Menta <i>th</i>	l Hygier	2004	36875
			Decedent's Name (First, Middle, Las				2. Date	e of Death		3. Time of Death
	Physicia /Medic		Phyllis Eileen	Bergh			No.	v. 13,	2004 Year	12:22 P ^M
	Examin		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, or Location	on of Death	4	c. County of Death	
			Suburban Hospital			Bethesd			Montgom	ery
	Funeral		5. Social Security Number 6. Social Security Number 1	9x 7.Age (i □M 21X1F	In yrs. last birthday) QQ Yrs.	If Under 1 Year If Und Months Days Hour		of Birth oth, Day, Yea		
	Director		Usual Residence of Decedent	н	83 Yrs.		Feb.	23, 1	1921 Conne	cticut
	/land		10a. State 10b. County	1	0c. City, Town or Lo	cation			1	0d. Inside City Limits
	Man a-f sh	ţo	Maryland Montgon	ery	Rockvi	11e				1 ☐ Yes 2X No
	th the	lrec	10e. Street and Number			10f. Zip Code		10g. 0	Citizen of What Cour	ntry?
	23a	rai	4904 Stickley Roa			20852			ted State	
21215-0036	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If Item 27 is marked other than "natural", or Items 23a or 28a-f show or other traumatic event. The Medical Examinar must be notified at	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced	12. Was Decedent Even Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:		Was Decedent of Hispanic If Yes, specify Cuban, Mexi 1 ☐ Yes 2 No Spec		s or No- etc.)	14. Race - Americ Black, White, Specify: Wh	
5-0	72 hc natur	eted	15. Decedent's Ed (Specify only highest gra		16a. Dece	dent's Usual Occupation kind of work done during n DO NOT use retired)	nost of working	16b.	Kind of Business/In	dustry
2	within one one.	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		DO NOT use retired) aker/Secreta:		Ora	n Home/Pu	hliching
	e filed within at Hygiene. I other than "		12 17. Father's Name (First, Middle, Last)		Homem		other's Name (First,			DITEILING
anc	ntal F ed of	Be	Robert Booth				Frances H		on comamo,	
Maryland	should be and Mental smarked o	٦ ک	19a, Informant's Name/Relationship (7	vpe, Print)	19b. Mailii	ng Address (Street and Nur			or Town, State, Zig	Code)
æ ≥	and 2 s ealth ar m 27 is nar trau		Lisa B. Nylund/D	•	10767	Cordage Walk	c. Columbia	a. Marv	land 2104	4
ē,	f Heal item 2 other		20a. Method of Disposition			esition (Name of matory or other place)	Date	20c.	Location - City or To	
E O	Page nent o int: if		1 ☐ Burial 2 🖾 Cremation 3 ☐ '4 ☐ Donation 5 ☐ Other (Specify	memoval from State		Crematorium, Inc	Novembe 20, 200		thesda, M	aryland
Baltimore,	permit. Pages 1 am Department of Heali Important: if item 2 any injury or other once.		21. Signature of Funeral Service Licent		00198 Rc	2. Name and Address of Fa bert A. Pumpl O West Montgo	ncility hrey Funer mery Aveni	al Hom	e/Rockvil kville. M	le. Inc. 20850-2805
			23a. Part1. Enter the disease, or composhock, or heart failure. List only	olications that caused the	e death. Do not ent	er the mode of dying, such	as cardiac or respira	atory arrest,		Approximate Interval Between
	Pnysician		Immediate Cause (Final disease or condition	A	บระเดิ	DC CARD	10 VALUE	AN I) (FALE	Onset and Death
	/Medical		resulting in death)		consequence of):	1	10 VASUU		1	MEARS MKWWW.
	Examiner		Sequentially list conditions,	b. LUNC	· CAW	CER			1	wkmm,
	ed sit	lne	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a c	consequence or):					
	and and II-tran	Examiner	that initiated events resulting in death) Last	c. Due to (or as a c	consequence of):					
58760,	icate be executed physician and s the burial-transit	alE		d						
687		edical								
P.O. Box	The law requires that the death certifi ste has been signed by the attending page 2 should be detached for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome of 1 ☐ Live birth 2 4 ☐ Pregnant at tin 9 ☐ Unknown	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of delive Month	ery Day Year
	that bed by deta	by Ph	Part II. Other significant conditions of	ontributing to death but i	not resulting in the u	nderlying cause given in Pa	art I. 236	. Did tobacco	use contribute to the	ne cause of death?
rds	quires in sign							1 ☐ Yes	2 □ No 3 □ Prob	ably 4 hknown
Records,	aw require s been sig 2 should b	Completed					248	. Was an		psy findings available
	The lay	шо					1	autopsy performed?	death?	mpletion of cause of
Vital	ysician: Th is certificete director, pag	Bec	25. Was case referred to medical examiner?			26. Pl	ace of Death (Check			
of <	Physic this ce	5	1 ☐ Yes 2.2 1No	Hospital: 1 Inpatient	-		Nursing Home 5			y)
n	ng I fter iner	on:	27. Manner of Death 1 Natural 5 □ Pending	28a. Date of Injury (Month, Day Y	'ear) 28b. Time o	Work?		scribe h <i>o</i> w inj	ury occurred	
Sic	death death ctor: /	Icat	2 Accident investigation 3 Suicide 6 Could not be		- At home, farm, str	M 1 Yes 2		ation (Street	and Number or Rura	I Route Number
Division	i or A efter Dirac	ertification:	4 Homicide determined	building, etc. (est, ractory, diffes	City	or Town, Sta	ite)	, , , , , , , , , , , , , , , , , , , ,
	To the Hospital or Attandi within 24 hours efter death. To the Funeral Diractor: A completely filled in by the fu	edlcal C			kamination and/or in	n occurred at the time, date vestigation, in my opinion, o				
į	To the within 2 To the complet	Me	29b. Signature and title of certifier	- m)	29c. License number	027	29d. D	Pate signed (Month,	Day, Year)
1	1		30. Name and address of person who		th (Item 23a) (Type,	Print) GEVIGETOWN	RO B	57463	DA mo	20814
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's		Son de	~			
			NUVZA	,004	100	L'anna				

		•	For State Registrar	State	of Maryla	nd / Dep <i>Ce</i>	artment ertificate	of Hea	alth ar e <i>ath</i>	nd Me		giene Reg. No.	2004	36876
			Decedent's Name (First, Middle, L	ast)							2. Date of De	ath		3. Time of Death
	Physicia		Joseph	Owen	Bur	ton					Month	Day	Year 200	4 02:15 M
	/Medic Examin		4a. Facility Name (If not institution, g		umber)		4b. City, To	own, or Lo	cation of I	Death		4c.	County of Dea	
			Holy Cross Hos	spital			Si1	lver	-			1	Mont	gomery
	Funeral			Sex 1XXXM 2□F	7. Age (In yr.	s. last birthday) If Under 1 Months		Under 24 Hours		8. Date of Birl (Month, Da	y, Year)	9. Bir	thplace (State or Foreign puntry)
	Director		N/A	<u> </u>		Yrs.]	15 ^{Min.}	Nov.	14,20	004 M	aryland
	and	}	Usual Residence of Decedent 10a. State 10b. County		10c. C	City, Town or L	.ocation							10d. Inside City Limits
	daryl f aho	ō	Maryland Montgo	nmerv			Si	.lver	Spri	ina				1 Tyes 2 No
	the 1	rect	10e. Street and Number				10f. Zip C		opii	LIIG		10g. Citi:	zen of What Co	
	3a or	ā	14347 Georgia A	Ave. T-	-2			20	0906			Ur	nited S	tates
	me 2	Funeral Director	11. Marital Status		cedent Ever in	U.S. 13	. Was Decede tf Yes, specif	nt of Hispa	anic Origin	n? (Spec	ify Yes or No		14. Race - Am	erican Indian,
0	or Ite	교	1 Never Married 2 Married	Armed F 1 Tes If Yes, G	2 X No		1 Yes 2		Specify:	rueno n	iican, etc.)		Black, Whi	White
2	ours iral',	d by	3 Widowed 4 Divorced	Year or	Dates:		10103 20		spoony.				эреспу.	
5	natu dica	ete	15. Decedent's (Specify only highest of)	(Giv	edent's Usual e kind of work DO NOT use	done duri	n ing most o	of workin	g	16b. Kir	nd of Business	/Industry
Y	within ane. than	Completed	Elementary/Secondary (0-12)	College	(1-4or 5+)	me.	N/A	100100)					N/A	
7	Hygie ther ther		17. Father's Name (First, Middle, Lat	st)				18	3. Mother's	s Name	(First, Middle,	Maiden	Sumame)	
<u> </u>	ld be ental ked o	To Be	Matthew A	Allen	Burton	n			Pa	aula	Mar	ie	Bur	ton
2	shou ind M imar		19a. Informant's Name/Relationship			19b. Mai	ling Address (Street and	Number	or Rural	Route Numbe	r, City or	Town, State,	Zip Code)
Ž	alth a		Matthew A. Burton	ı / Fath	er	14	347 Ge	orgia	a Ave	e. T-	-2; Sil	ver	Spring	, MD 20906
ב ה	as t a		20a. Method of Disposition		20b.	Place of Disp cemetery, cri	osition (Name ematory or oth	e of ner place)		Da	ate	20c. Lo	cation - City or	Town, State
Ĭ	Page nent o		1 ☐ Burial 2 [XCremation 3 `4 ☐ Donation 5 ☐ Other (Spec		Cl	hesapea	ke Cre	mator	ry 1	1/19	9/04	E	Beltsvi	11e, MD
Daillio	permit. Pages t and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Iteme 23s or 28s-f ahow any injury or other traumatic event, the Medical Evantret must be notified at 906s.		21. Signature of Funeral Service Lic	ensee	~ M003		Rapp F	Address of unera	a I an	nd Ci Silv	rematio	n Se	rvices	20910
			23a. Part1. Enter the disease, or co	mplications that	caused the de									Approximate Interval Between
Ě	Physician		shock, or heart failure. List on immediate Cause (Final	ry one cause on	each line.	Park	1.0	0	000	111-				Onset and Death
	/Medical		disease or condition resulting in death)	a. Due to	o (or as a conse	equence of):	m	- 40						
	Examiner		Conventially liet conditions	b										
100	D =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to	o (or as a conse	equence of):								
	ecute ind trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c										
Š,	oe exi	Ē	1050king in dodiny cast	Due to	o (or as a conse	equence or):								
00/00	The law requires that the death certificate be executed ate has been signed by the attending physicien and bage 2 should be detached for use as the burial-transit	dicai	•	d										
X	ding se as	/Me	IF FEMALE:	23c. If yes, o	utcome of preg	nancy						2	3d. Date of de	livery
0	atten atten i for u	Physician/M	23b. Was decedent pregnant in the past 12 months?	1 🗀 Live	birth 2 ☐ Fe gnant at time of	tal death 3	☐ Ectopic preg ☐ Other (spec					-	Month	Day Year
	the d y the ached	ysi	1 Yes 2 No 9 Unknown	9□ Unk	nown			,,						
<u>,</u>	that ned b	by Pł	Part II. Dther significant conditions	contributing to	death but not re	esulting in the	underlying cau	use given i	in Part I.		23e. Did to	obacco u	se contribute to	the cause of death?
cords	quire n sig	d be									10	res 2	No 3□P	robably 4 Unknown
၁	s bee	Completed									24a. Was		24b. Were a	utopsy findings available completion of cause of
ŗ	The laste has page	E										med?	death?	
N I G		ВеС	25. Was case referred to medical examiner?					26	6. Place o	of Death	(Check only o			
	Physician: r this certific ral director,	To E	1 Yes 2 No	Hospital: 1	Inpatient 2	☐ ER/Outpati	ent 3 DOA	Other:	4 🗌 Nurs	sing Hom	ne 5□Resid	dence 6	Other (Spe	city)
0	fing Phys		27. Manner of Death 1 XNatural 5 ☐ Pending	28a. Dat (Mo	e of Injury onth, Day Year)	28b. Time Injury		c. Injury at Work?			8d. Describe I	now injury	occurred	
SIO	tendi eath. tor: A the fu	cati	2 ☐ Accident investigat 3 ☐ Suicide 6 ☐ Could not	he			М		s 2 □ No		04.1			
DIVISION OF	or At or or At or At or At or At or At or At or At or At or At or at or	Certification:	4 Homicide determine	200. Plat	ce of Injury - At ding, etc. (Spe	home, tarm, s cify)	street, factory,	office		2	City or Tov			ural Route Number,
_	pital ours a aral filled		29a. Certifier 1 X Certifying	Physicien: To ti	ne best of my k	nowledge dea	ath occurred at	t the time	date and	place a	nd due to the	causa(s)	and manner a	stated
	To the Hospital or Attending Physician: within 24 hours after death. To the Funaral Director: After this certific completely filled in by the funeral director,	ledical	(Check only 2 Medicat Ex	aminer: On the	basis of exami inner stated.	nation and/or	investigation, i	in my opini	ion, death	occurre	d at the time,	date and	place, and due	to the cause(s)
	To th withir To th comp	Me	29b. Signature and title of certifier	10/	0	1//	296.	License nu	umber	_		29d. Date	e signed (Moni	h, Day, Year)
) er	17	we			D17	7298			Nov	rember	15, 2004
			30. Name and address of person wh					-01	MD 1	20708	 R			
	Sta		Jed D. Gould M 31. Date filed (Month, Day, Year)		Registrar's Sig			.cl, i	2 (111)	20700	J			
	Registr	rar	NOV 2 0 2004	Jan Bur	4 10	7								

Registrar DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No-2. Date of Death 1. Decedent's Name (First Middle Last) MARTER 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number, -01D BALLIMORE BALTIMORE 8. Date of Birth If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthdav) Birthplace (State or Foreign Country) N.C. 1 M 2 Months Days Hours 84 212-22-9549 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits BALTIMORE XX Yes 2□No MD BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? IISA 21222 417 MAPLE LANE 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 X No Specify: Specify: BLACK 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) BURKES RESTUARANT CHEFF 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) REBECCA BLANKS BLANKS EVA 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 601 ONETA DRIVE, WESTMINISTER, MD 21157 SANDRA FERGUSON/DAUGHTER 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 □ Burial 2 □ Cremation 3 □ Removal from State 11/23/04 OWINGS MILLS, MD GARRISON VET. CEM 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility JAMES A. MORTON & SONS F.H, INC 21. Signature of Funeral Service Licensee 1701 LAURENS STREET, BALTO., MD ant 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, fock, or heart failure. List only one cause on each line. Approximate Intervel Between Onset and Death < 8031 Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): DEMENTIA Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of): PKINISONS IRATION PNEUMONIA Part II. Other eignificent conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobecco use contribute to the ceuse of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were eutopsy findings available prior to completion of cause of death? 24a. Was en autopsy performed? 1 Tes 2 No 1 ☐ Yes 2 XNo 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes No 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred

Physician /Medical Examiner

Physician

/Medical

Director

Be Completed by Funeral

ဥ

Examiner

Funeral

Director

Pages 1 and 2 should be filed within 72 hours after death with the Maryland

If item 27 is marked other then "neturel", or items 23s or 28e-f shor or other treumstic event, the Madical Examiner must be notified at

Depertment of Health and Mental Important: If item 27 Is marked o any Injury or other treumatic eve

Baltimore,

Physiclan/Medical Examiner within 24 hours effer death.

To the Funerel Director: After this certificate has been sit completely filled in by the funeral director, page 2 should I Certification: To Medical

or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

<u>δ</u> Be Completed

2 Accident 3 Suicide

(Check only one)

29a. Certifier

29b. Signature and title of certifier

4 Homicide

5 Pending investigation 6 Could not be determined

NOV 2 2 2004

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Yes 2 🗆 No

29c. License number

1 Certifying Phyeicien: To the best of my knowledge, death occurred at the time, date and place, end due to the ceuse(s) and manner es steted.

2 Medical Exeminer: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rurel Route Number, City or Town, Stete)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MCNEAL BROCKINGTONIMD 31. Date filed (Month, Day, Year)

6609 32. Registrar's Signature

TERSTOWN RD. TO.

State Registrar

DHMH 16 Rev 6/95

State of Maryland / Department of Health and Mental Hygiene 2 For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 1):40 AM 2004 /Medical Name (If not institution, give street and number)
ORD GALDENS -4720 HARFORD RD 4c. County of Death **Examiner** Baltimore Baltimore If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, 9. Birthplace (State or Foreign **Funeral** Marke 1 ▼M 2 □ F 68 Director Usual Residence of Decedent Town or Location 10d. Inside City Limits 10a. State 10b. County or 28a-f show Examiner must be notified at MIIMORE 1 Yes 2 □ No Director 10g. Citizen of What Country? et and Number 10f. Zip Code 41213 or Herns 23a Completed by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cultan, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 MNo 14. Race - American Indian Peges 1 and 2 should be filed within 72 hours after onent of Heelth and Mental Hygiene. ent: If Item 27 is marked other than "naturel", or Item ever Married 2 Married Baltimore, Maryland 21215-0036 1 TYes 2 No If Yes, Give Year or Dates: 3 Widowed 4 Divorced 16b. Kind of Business/Industry event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation Elementary/Secondary (0-12) College (1-4or 5+) RANSPORTATION 17. Father's Name (First, Middle, Last Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) FRANCINE CAPLE - FORD DANGHTER 1409 DAR L DARLEY 20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State CETAR HU COMETERY 11.22.04 BATIMORE WARYLAND
22. Name and Address & Facility VAUGHT C. GREENE FUNERAL HOME permit. Pege Department of importent: If any injury or * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee ROAD BALTIMORE, MO 23a. Part1. Enter the disease, of complications that caused the death. Do not explose, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Hospitel or Attending Physicien: The law requires that the death certificate be executed burial-transit Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months?
1 Yes 2 No 4 Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 🗌 Yes 2 X No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 🗌 Yes 2 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 🗌 Yes 2 X 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28b. Time of Injury 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. 2 Accident investigation hours after deathuneral Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide within 24 hours a To the Funeral C Medical 29a. Certifier crifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signatur In We of certifier 29d. Date signed (Month, Day, Year) Name and address of person who completed cause of death (Item 23a) (Type, Print's IVA) Ballimore MO 21239 31. Date filed (Month, Day, Year) 32. Registrar's Signature State NOV 2 2 2004 Registrar

ORIGINAL

Registrar

		•	For State Registrar	State of	Marylan	•		f Health a of Death		lental Hy	giene Reg. No	n n 1,	36000
	Dhusisis		1. Decedent's Name (First, Middle, La	st)						2. Date of Dea	ath Day	Year	3. Time of Death
	Physicia /Medic	ai .	MARK	E		TION				Nov	il	2004	1225 PM
	Examin	er	4a. Facility Name (If not institution, give		ber) Nedica	1 Control	-	n, or Location			4c. Coi	unty of Death	0:1
			University of Mar. 5. Social Security Number 6. S	1	. Age (In yrs. I		If Under 1 Ye	Saltiv	24 Hrs.		'n	Baltimo	
	Funeral Director		218-46-8669	M 2□F	58		Months Da		Min.	(Month, Da	y, Year)		lace (State or Foreign try)
	-		Usual Residence of Decedent							September	16, 1946	- N	Naryland
	urylan show		10a. State 10b. County		10c. City	y, Town or Lo	cation					11	0d. Inside City Limits 1 ☐ Yes 2 🕱 No
	Ba-f e	Director		ore City				Baltimore	е				
	with ti		10e. Street and Number				10f. Zip Coo	^{1e} 212	212		10g. Citizen	of What Coun	
	ns 23	eral	728 East Lake Avenue	12. Was Deced	lent Ever in U.	S 13 V	Vas Decedent			ecity Yes or No	- 14.	Race - Americ	
30	be filed within 72 hours after deeth with the Maryland ital Hygiene. I do ther than "natural", or items 23a or 28a-f ehow event, it a Madical Examination in the intilitied at	by Funeral	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Ford 1 Yes 2 If Yes, Give Year or Da	es?/ 2 XNo	1	Yes, specify (/		ecify Yes or No Rican, etc.)		Black, White,	
2-003p	2 hou atura	ted	15. Decedent's Ed	ducation		16a. Decec	ent's Usual Oc	cupation			16b. Kind d	of Business/Ind	dustry
2	hin 7.	Completed	(Specify only highest gra Elementary/Secondary (0-12)	College (1-	4or 5+)	(Give life. L	kind of work do DO NDT use re	one during mos tired)	st of work	ing	C	Custom Mi	llworking
7	filed wit Hygiene other the	Con		4				Manager					
aua	ital Hydrad oth	Be	17. Father's Name (First, Middle, Last)					18. Moth	er's Name	First, Middle,			
<u> </u>	2 should be filed and Mental Hygi le marked other aumatic event, I	ဥ		Campion		10h Mailia	- Add /Ot		C		oinete S		Codel
<u>8</u>	d 2 sh th and 7 ie n traun		19a. Informant's Name/Relationship (a <i>l Route Numbe</i> more, Mary			C00e)
a)	of Health Itam 27	-	Ms. Marylee Barnes 20a. Method of Disposition	Spo	20b. P	lace of Dispos	sition (Name o	f		Date		on - City or To	wn, State
бантіто	mit. Pages 1 and 2 should loatment of Health and Men ortant: if Itam 27 ie marke in jury or other traumalic.		1 ☐ Burial 2 ☐ Cremation 3 ☐ '4 ☐ Donation 5 ☐ Other (Specif		tate		natory`or other		11/1	15/2004		Baltimore	e. MD
	permit. Page Department of important: if any injury or once.	}	21. Signature of Funeral Service Licer				ew Crema . Name and Ad	Itory Idress of Facili					
ñ	Depa impo any i		Oftenlule S	lad	moos	15	Slack 3871	K Funeral	Home,	P.A. Pike Ellicott	City ME	21043	
	Physician /Medical	-	23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	one cause on ea	used the death ch line. +as+a or as a consequ	tic i	er the mode of	dying, such as	cardiac	or respiratory ar	rest,	21043	Approximate Interval Between Onset and Death
	Examiner			he	mont	VSI T	•						
		Jer	Sequentially list conditions, if any, leading to immediate	Due to (a	r as a consequ	ence of):							
	ate be executed hysician and the burial-transit	Examiner	Cause (Disease or injury that initiated events	c									
νoς,	e exe ian a urial-	EX	resulting in death) Last	Due to (o	r as a consequ	uence of):							
00/0		dicai		d									
OX O	ding p	/Me	IF FEMALE:	23c. If yes, outc	ome of pregna	ncv					334	Date of deliver	2/
2	to death certificate the attending phys hed for use as the	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 Live bir	th 2 ☐ Fetal nt at time of de	death 3	Ectopic pregna Other (specify		<u>.</u>		230.		Day Year
7.	law requires that the desas been signed by the a		Part II. Other significant conditions of	ontributing to dea	ath but not resu	ulting in the ur	derlying cause	given in Part I		23e. Did to	bacco use o	contribute to the	e cause of death?
ds	uires sign id be	d by								1 🗆 Y	′es 2□N	o 3 Proba	ably 4 Unknown
cords	w require been signature should t	Completed								24a. Was	an 24	b. Were autop	osy findings available
Ů L	9 4 9	шс								autop perfor	rmed2	death?	npletion of cause of 2□No
VII	rician: Th certificate rector, pag	0	25. Was case referred to medical					26. Place	of Death	(Check only o	20 No	1 🗆 103	2010
	Physician: this certific ral director,	ToB	examiner? 1 Yes 2 No	Hospital: 1 ☐ In	patient 2 🗷	ER/Outpatien	3 DOA	Other: 4 🗆 Nu	ursing Ho	me 5 Resid	lence 6 🗆	Other (Specify)
0	ding Phys th. After this funeral dir		27. Manner of Death 1 ■ Natural 5 □ Pending	28a. Date of (Month	Injury , Day Year)	28b. Time of Injury	28c. I	njury at Work?		28d. Describe h	ow injury oc	curred	
<u>0</u>	endir eath. or: Al	catic	2 ☐ Accident investigation				М	Yes 2					
DIVISION	To the Hospital or Attending within 24 hours effer death. To the Funeral Director: After completely filled in by the funer	Certification:	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	289. Place d	of Inju ry - At ho g, etc. <i>(Specif</i> y	ome, farm, stre	et, factory, off	ce		28f. Location (S City or Tow		umber or Rural	Route Number,
	ne Hospitai n 24 hours e ne Funerai eletely filled	Medicai	29a. Certifier 1		sis of examinat								
	To the compl	Σ	29b. Signature and title of contifier					ense number				gned (Month, L	Day, Year)
1			your	~ D			7	147	37		No	V 11	2004
\	ν,		30. Name and address of person who Manuel Torr	د که	22 5	outh c		Street	, Bu	Itimore	MD	, 212	01
	Sta		31. Date filed (Month, Day, Year)	32. Re	gistrar's Signa	ture		9					
	Registr		NOV 2 2	ZUU4 P	Deper	~ E	1 do	relat					
UHI	MH 17 Rev 1/20	V1				-	- /	15.0					

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			Certificate of Death			26001
			1. Decedant's Nama (First, Middla, Last)	2. Data of Dea	th 2004	9. Time & Dich
	Physici /Medic	an	Sandra Carpenter	Novembe	Dey Year	18:50 pm
\$	Examin	aı er	4a Facility Nama (If not institution, giva street and number) 4b. City Town, or Lo			h
			Forest Haven Nursing Home Cutonski	11e	Baltimo	YC
	Funeral		5. Social Sacurity Number 6. Sax 7. Aga (In yrs. last birthday) 17 Undar 1 Yaar 17 Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day Mar 6,	9. Birt	hplaca (State or Foraign untry) y Land
	Director		213-40-0793 1 M 2 A F 61 Yrs. Usual Residence of Decedent	mar o,	1945 Mar.	y Land
	Pud H	ŀ	10a. Stata 10b. County 10c. City, Town or Location			10d. Inside City Limits
	the Marylen 28a-f show	ğ	MD Baltimore Catonsville			1 ☐ Yas 2 ☑ No
	r 28a-f	Director	10e. Street and Number 10f. Zip Code		10g. Citizan of What Co	untry?
	filed within 72 hours efter death with the Marylend Hyglene. ther than "natural", or flems 23a or 28e-f show int, the Medical Examiner must be notified at		315 Ingleside Avenue 21228		USA	
	dea	Funerai	11. Marital Status 12. Was Decedent Evar in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Spif Yas, specify Cuban, Maxican, Puarto	ecify Yas or No- Rican, atc.)	14. Race - Ame Black, White	
20	or ft		1 ☐ Navar Marriad 2 ☐ Married 1 ☐ Yas 2 ☑ No		Specify: Wh	
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Maryland 21215-0020	2 should be f n end Mental I is marked of raumatic eve		19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Straat and Number or Run	el Route Numbe	r, City or Town, State, 2	Zip Coda)
	1 end 2 Health em 27 is		Forest Haven Nursing Home 315 Ingleside Avenue	Catons	ville, MD	21228
Baltimore,	iges 1 and 2 should be filed nt of Health and Mantal Hyg if item 27 is marked other or other traumatic event,		20a. Mathod of Disposition 1 □ Burial 2 □ Cramation 3 □ Removal from Stata 20b. Place of Disposition (Nama of cemetery, crematory or other place)	Date	20c. Location - City or	Town, Stata
Ĕ	nit. Peges ertment of le ortant: if its injury or of		4 Donation 5 Dothar (Specify) in state			
alt	permit. Peg Depertment Important: i any injury o		21. Signature of Funeral Struces Licensee Ronald S. Wade, Director State Anatomy Boar	d 655 W	. Baltimore	Street
ш	20 = 20		Baltimore, MD 212			
			23a. Part 1. Entar tha disaasa, or complications that caused the death. Do not anter the mode of dying, such as cardiac shock, or haart failure. List only one cause on each line.	or respiratory arr	rest,	Approximate Interval Between
	Physician		Nous of No. C. FOERP.			Onsat and Death
A. S.	/Medical Examiner		Immediata Cause (Final disaasa or condition rasulting in death) a.	omsch	LAX DI	IEALE
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	ifficete be executed g physician and es the buriel-transit	Xai	Sequentially list conditions, if any, laading to immadiata causa. Entar Undarlying Causa (Disasas or injury that initiated avants Due to (or es e consequence of): Due to (or as a consequence of):			
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	Physician: The law requires that the death cer this certificate hes been signed by the ettendir rel director, page 2 should be deteched for use	Physician/N	Part II. Other significant conditions contributing to death but not resulting in tha underlying cause given in Part I.	23b. Did to	obacco usa contributa	to tha causa of death?
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Division of Vital Records,	law require es been si 2 should l	Completed		24a. Was a perfor	med?	Were autopsy findings available prior to completion of cause
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Ĭ;	iing Physician: The I h. After this certificete he funerel director, page	Be	25. Was case referred to medical examiner? Hospital: Other: Other:	Was transfered		
ot	Physi this rel dir	۲.	1 Inpatient 2 EH/Outpatient 3 DOA Nursing Ho		ence 6 ⊡Other <i>(Spec</i> ow inju ry occurred	cify)
L C	P 2 2 2	[Natural 5 Pending (Month, Day Year) Injury Work?	200. 200020	ow injury coccinco	
isi	death. ctor: A y the fu	fica	3 Suicida 6 Could not be 28a. Place of Injury - At homa, farm, streat, factory, office	28f. Location (S	treet and Number or Ru	ıral Routa Number,
S	effer Olred	Certification:	4 ☐ Homicide building, etc. (Specify)	City or Tow	n, State)	
	To the Hospital or Attendii within 24 hours efter death. To the Funeral Director: A completely filled in by the fu	aic	29a. Certifiar Certifying Physician: To tha best of my knowledge, death occurred at the time, date and place,	and due to the c	ause(s) and mannar as	steted.
	in 24 he Fu pletel	edlcai	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurr and manner stated.			
	Vithi To the	Σ	29b. Signatura and titla of certifiar 29c. License number	2	29d. Date signed (Month	h, Day, Year)
			Jasven Kalely D28195		11/18/04	
			30. Name and address of person who complated cause of death (Item 23a) (Type, Print)		A. FRA	IDMI
		ľ	MANGEM CARHAWI, 1220 MARK HEIG	7117	TVE INT	2/1202
	Sta	-	31. Data filed (Month, Day, Yaar) 32. Registrar's Signatura			4010
	Registr	al	NIV 2 Z 1004 Deriva O Social			

DHMH 16 Rev 6/95

State of Maryland / Department of Health and Mental Hygiene 36882 Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Theodore C. Cheston November 14. 2004 10:26 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Suburban Hospital Bethesda Montgomery If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Birthplace (State or Foreign Country) Months 1 X M 2 ☐ F 217-36-7566 Director May 30, 1922 Austria Usual Residence of Decedent with the Maryland 10b. County 10c. City, Town or Location in than "natural", or Items 23a or 28a-f show the Modical Examiner must be notified at 10d. Inside City Limits 1 ☐ Yes 2 No Maryland Montgomery Bethesda Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10120 Parkwood Terrace 20814 death y Funeral <u>United States</u> 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status hours after 1 ☐ Yes 2 📉 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married Baltimore. Maryland 21215-0036 1 ☐ Yes 2 No Specify: à Specify 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filed within 72 and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 4 Electrical Engineer Research Laboratory permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked other any injury or other traumatic event ADEs. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 2 Edwin Czeczowiczka Caroline Reitlinger 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sheila Cheston/ Daughter 7817 Hampden Lane Bethesda, Maryland 20814 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Montgomery Crematorium Inc. November 22, 2004 * 4 ☐ Donation 5 ☐ Other (Specify) rium Inc. 22, 2004 Bethesda, Maryland
22. Name and Address of Facility Robert A. Pumphrey Funeral Home/
Bethesda-Chevy Chase, Inc., 7557 Wisconsin Avenue 21. Signature of Euneral Service Licenses M00335 Bethesda, Maryland 20814-3501 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Shy-Drager Syndrome /Medical Due to (or as a consequence of) Examiner Parkinson's Syndrome Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of). Examiner certificate be executed burial-transit and that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 the attending physician Physician/Medical as the IF FEMALE: esn 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Month Year 4 Pregnant at time of death 5 Other (specify) P.O. F ☐ Yes 2 ☐ No 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. å Systolic Hypertension, Renal Insufficiency 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed Progressive Non-Alzheimer's Dementia 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy pac Coronary Artery Disease 1 🗌 Yes 2**X** No 1 ☐ Yes 2 ☐ No Physician: uneral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 AFR/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 XNo 2 this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: To the Hospital or Attending I within 24 hours after death. To the Funeral Director; After 1 XNatural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by t 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check or one) 29b. Signature nd title of certifie 29c. License number 29d. Date signed (Month, Day, Year) D46101 November 15, 2004 dress of person was completed cause of death (Item 23a) (Type, Print) 30. Name and Povar, M.D., 8700 Georgia Avenue, #400, Silver Spring, Maryland 20910 31. Date filed (Month, NOV 2 2 32. Registrar's Signature 2004 Registrar

			1 - For Stata Registrar	State of	Marylan		artmen rtificat				lental H	ygien Reg. N	201	04	3688	धर
	Physici	an	1. Decedent's Name (First, Middle,	Last)							2. Date of D	eath			3. Time of De	
	/Medi		Gayle Corasani								Novem	ber	18th	Year 2004	3.00	AM
	Examir	er	4a. Facility Name (If not institution, Union Memorial	•	er)		4b. City,		Location			4	c. County	of Death		
	Funeral			S. Sex 7.	Age (In yrs.	last birthdav)	If Under		Balti If Under		8 Date of B	irth		O Binto	-1 (01-15	
ь	Director		215-42-1450	1□M 2ØF		61 Yrs.	Months	Days	Hours	Min.	8. Date of B (Month, D Oct 12	ay, Yea	r) 943	Cour	place <i>(St</i> ate or Fi ntry) rland	oreign
	and *		Usual Residence of Decedent 10a. State 10b. County		10a Cib	y, Town or Lo										
	Maryli f sho	ō	MD Baltim	loro		kville								1	10d. Inside City L 1 ☐ Yes 2	
	r 28e	Director	10e. Street and Number	оте	Pai	KATITE	10f. Zip	Code				100.0	itizen of V	What Cour		2140
	15 with with 23e o		5 Carriage Lamp	Court			2123						ited		•	
	ems	Iner	11. Marital Status	12. Was Decede Armed Force	ent Ever in U.	S. 13.	Was Deced	lent of His	spanic Ori	gin? (Spe	ecify Yes or N Rican, etc.)		14. Race	e - Americ	can Indian,	
36	s afte	by Funeral	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	d 1 ☐ Yes 2 If Yes, Give	™ No		1 □ Yes 2		Specify:	i, rueno	nican, etc.)		Specify	k, White,	etc.	
8	thour	ed b	15. Decedent's	Year or Date	98:	16a. Deced	lent's Heur	I Ossusa	tion				1	White		
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and	ould be tiled within 72 hours after death with the Maryland Mental Hygiene. erked other then "neturel", or items 23e or 28e-f show etic event, the Medical Examinat must be recitied at	Be	17. Father's Name (First, Middle, La	,				1			(First, Middle			e)		
Maryland 21215-0036	hould id Mer marke	²	Milton Adam Nov			105 14-11					Gale Me					
<u>8</u>	nd 2 s tith ar 27 is r treu		Mr. Brent Harris								/ Route Numb		or Town,	State, Zip	Code)	
e,	ss 1 au of Hea item othe		20a. Method of Disposition		20b. PI	ace of Dispos	sition (Nam	e of	T	D	ate		ocation -	City or To	wn, State	
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Balt	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. The mortent: If item 27 is marked other then "neturel; or Items 23e or 28e-f show any injury or other treumetic event, the Medical Examinat must be notified at anomy injury or other treumetic event, the Medical Examinat must be notified at anomy.		21. Signature of Funeral Service Lic	ensee	MDO98	10 22	Name and	Address	of Facility	Fune	ral Al					
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	ecuter and trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Hype	LR FO	(7)									1 42.	
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280	death certificate be executed e attending physician and ed for use as the burial-transit	edical		d					-							
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VII	Physicien: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?								(Check only o	ne)				
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	fter free	tion	1 ⊠Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of In (Month, D	ay Year)	28b. Time of Injury	280 M	c. Injury a Work?	ıt ıs 2.⊡N		8d. Describe h	now injur	y occurred	d		
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5	itel or rs afte al Dir ed in	Certification:	4 Homiciae	building, e	etc." (Specify)						City or Tou	vn, State)	o, 1121 Q.	TODIO TVAITIDOS,	
		edical	29a. Certifier 1 Certifying P (Check only one) 2 Medical Exa	Physician: To the besommer: On the basis and manners	or examination	ledge, death on and/or inve	occurred at estigation, in	the time, n my opin	date and ion, death	place, ar	nd due to the o	cause(s) date and	and manr I place, an	ner as sta	ted. he cause(s)	
	To th To th comp		29b. Signature and title of certifier				29c. l	License n	number			29d. Dat	e signed (Month, D	ay, Year)	
,		,	▶ Bangaria Ka	mal C.	M.D	1	AT	24	389	146	1	YOUR	mber	10	th 200	4
(2-119		30. Name and address of person who													-
	Stat		KAMALKUMAR Cx. 31. Date filed (Month, Day, Year)	BANGOR 32 Banie	IA Z	101 E	ast U1	niver	sity i	Par Ke	way Bo	altin	none	MD	-21218	3
	Registra	چ ا	NOV 2 0 2004	2	J. Signato	- 10										

ian	1. Decedent's Name (First, Middle, Last	1)	·- · · · · · · · · · · · · · · · · · ·			2. Date of Death	2004 1. No.	3. Time of Dea
ical	Brenda	Diane		Carter		Month	16 2004	5:45p
ner	4a. Facility Name (If not institution, give 2821 Miles Aven			4b. City, Town, or Lo Baltim			4c. County of Dea	
	213-72-2410	7. Age (In yrs.	last birthday) Yrs.		Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 197–28–5	9. Bir 8	thplace (State or Foountry) N.C.
	Usual Residence of Decedent 10a. State 10b. County	10c. C	ity, Town or Lo	cation				10d. Inside City L
Director		AV	Balt	imore				1 XYes 2
	10e. Street and Number 2821 Miles Ave.			10f. Zip Code 21211		100	g. Citizen of What Co USA	ountry?
/ Funeral	11. Marital Status 1 Never Married 2 Married	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 X No If Yes, Give		Was Decedent of Hispa f Yes, specify Cuban, M I □ Yes 2 No S	anic Origin? (Spe Mexican, Puerto I	cify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit	
ed by	3 Widowed 4 Divorced	Year or Dates:		lent's Usual Occupation		16	Sb. Kind of Business	
Completed	(Specify only highest grad Elementary/Secondary (0-12)	de completed) College (1-4or 5+)	(Give	kind of work done durii DO NOT use retired)		ng		
	11th grade 17. Father's Name (First, Middle, Last)	******		usekeeping	Mother's Name	(First, Middle, Ma	Tremont	Hotel
o Be	Williard 3	Willard J. C		16	Maggie		Graham	
-	19a. Informant's Name/Relationship (T)	ype, Print)	19b. Mailir	ng Address (Street and				
L	Mona Lisa Carter	Daughter		l Miles Ave				
	20a. Method of Disposition 1 XBurial 2 □ Cremation 3 □ F	Removal from State	cemetery, crer	sition (Name of natory or other place)			c. Location - City or	
	 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service License 			on Cem. Name and Address o	11-23		ansdowne, imore, Md	
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Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or as a consect b. AIOS Due to (or as a consect c. Due to (or as a consect c.	quence of):	len				
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien [] 36885 1 - For State Registra Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** Year 2:30 A M 18 ROBERT LEE DAVENPORT 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE N/A MANORCARE If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Days Hours Min. 1□M 2□F Yrs Director 03-26-1928 218-22-9624 76 MD Usual Residence of Decedent permit. Pages 1 and 2 should be tiled within 72 hours atter death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "netural" ~ " any injury or other traumatic average. 10a. State 10b. County 10c. City, Town or Location 10d. fnside City Limits BALTIMORE MD N/A 1 XYes 2 □No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21215 4569 THE STRAND Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Never Married 2 Married XYes 2 □ No Yes Give 1 Yes 2 No Specify: BLACK 3 ☐ Widowed 4 ☐ Divorced Year or Dates: 51-71 16a. Decedent's Usual Occupation (Give kind of work done during life. OO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) ring most of working Elementary/Secondary (0-12) College (1-4or 5+) UNITED WAY DIRECTOR 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be FANNIE COLEMAN JAMES DAVENPORT 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) CHARLES DAVENPORT/BROTHER 4569 THE STRAND, BALTIMORE, MD 21215 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) GARRISON FOREST VET. 11/29/04 OWINGS MILLS, MD 22. Name and Address of Facility JAMES A. MORTON & SONS F.H., 21. Signature of Funeral Service Licensee 1701 LAURENS STREET, BALTIMORE, MD 21217 23a. Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician Endstage 12/ FIRE /Medical resulting in death) Due to (or as a nsequence in Examiner Sequentially list conditions, Due to (or as a consequence of) Examiner thany, leading to him sold cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed use as the burial-transit attending physician and for use as the burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part If. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ page 2 should be 3 Probably 4 Denknown 1 ☐ Yes 2 ☐ No Be Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 2 \(\text{No}\) □ Yes 2 No Hospital or Attanding Physician: tuneral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 2 No Certification: To 1 🗌 Yes 1 Inpatient 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Atter 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident after death Diractor: / filled in by the 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 / Homicide within 24 hours To the Funeral 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 2

DHMH 17 Rev 1/2001

State Registrar MAIN

32. Pegistrar's Signature

30. Name and address of Ferson who completed cause of death (Item 23a) (Type, Print)

2 2004

31. Date filed (Month

State of Maryland / Department of Health and Mental Hygiene 0014 36886 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day 19 2004 **Physician** November 9:45p Dorothy Dixon /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Fairhaven Sykesville Carroll If Under 1 Year If Under 24 Hrs. Months Days Hours Min. Birthplace (State or Foreign Country)
 WV 8. Date of Birth (Month, Day, Year) July 30 1914 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Months 1□M 2√□F Yrs. 218-05-9898 July Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County or than "naturel", or iteme 23a or 28a-f ehow the Medical Examiner roust be recitived at 1 X Yes 2 □ No Sykesville Md Carrol1 Completed by Funeral Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21784 USA 7200 Third Avenue 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specifywhite 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) homemaker domestic permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygier Importent: If item 27 is marked other It any injury or other treumatic event, Ite once. 18. Mother's Name (First, Middle, Meiden Sumame) 17. Father's Name (First, Middle, Last) Be Dora May Rohrbaugh Gilbert Roger Proudfoot 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1136 Falls Hill Dr. #B-6 Sykesville, MD 21784 Mrs. Marilyn Loewer (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Timonium, MD 11-23-04 Dulanev Vallev Mem. 22. Name and Address of FacilitHaight Funeral Home & Chapel 21. Signature of Funeral Service Licensee > (Jacquofaight Herbert P.O. Box 195 Sykesville, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Met. 2 MD Physician /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Uisease or injury that initiated events Due to (or as a consequence of): Examine attending physician and for use as the burial-transit The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month Dav Year in the past 12 months? 1□Live bitti 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Athaissef-19102 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 Yes 2 No 1 Yes 2 1No To the Hospitel or Attending Physicien: within 24 hours after death.

To the Funerel Director: After this certifica completely filled in by the funeral director, F. 26. Place of Death Check on one 25. Was case referred to medical examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 27. Manner of Death Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 [] Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Mgnth, Dey, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) vs.hell 31. Date filed (Month, Day, Year) 32. Registrar's Signature State NOV 2 2 2004 Registrar

			1 - For State Registrar	State of Maryland	Department of Certificate o	Health and Men f Death	tal Hygien		36887
			1. Decedent's Name (First, Middle, La	nst)			Date of Death Month Da	ay Year	3. Time of Death
	Physicia /Medic		ALANTE	OzVITO			wamber		3:10 A. M.
	Examin		4a. Facility Name (If not institution, given	ve street and number)	4b. City, Town	, or Location of Death	4	c. County of Death	
			STELLA MARIS	HOSPICE		NUM		3ALTIMON	
	Funeral			Sex 7. Age (In yrs. last	birthday) If Under 1 Yea Months Day		Date of Birth Month, Day, Year	7	lace (State or Foreign try)
	Director		Usual Residence of Decedent	93			FT-13 19	11 15000:	207,001
	land ow		10a. State 10b. County	10c. City, T	own or Location			10	0d. Inside City Limits
	Mary -f sh	ţo	COMPO BATTE	2/ 3800	nozwi				1 ☐ Yes 2 No
	r 28a	Director	10e. Street and Number	11.	10f. Zip Code)	10g. C	itizen of What Coun	try?
	h with	ie D	40 Arosa Pic	ROLL APTION	2125	34	\	J.S.A.	
	deat	Funerai	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent o	f Hispanic Origin? (Specify uban, Mexican, Puerto Rica	Yes or No-	14. Race - America Black, White, e	
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2	filed Hygi sther		17. Father's Name (First, Middle, Las	t)	3101.61 114	18. Mother's Name (Fi	rst, Middle, Maide		
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	and 2 ealth a n 27 la		TERESA O. BER	9 MAHOUF	2510KI FOX	STER ROAD	Tows	~ MARY	1200 3138P
ře,	iges 1 and 2 should be filed within 72 hours after death with the Marylan It of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23s or 28s-1 show or other treumatic event. The Ms lical Exam are must be notified at		20a. Method of Disposition	20b. Plac	e of Disposition (Name of etery, crematory or other p	place) OV Date		Location - City or To-	wn, State
Ē	Pages nent of I ont: If its iry or o		1 ☐ Burial 2 ☑ Cremation 3 ☐ 1 ☐ Donation 5 ☐ Other (Spec		12 FULL BALCH	HUET 300P	'\	41H 725	Charlesa ()
Baltimore,	permit. Pages 1 and 2 Department of Health Importent: If item 27 any injury or other tr.		21. Signature + Funera (Sprvice Lice	ansve	22. Name and Add	tress of Facility	Funcai	ANDLAMA	
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п			23a. Part1. Enter the disease, or con shock, or heart faiture. List only	mplications that caused the death. I y one cause on each line.	Do not enter the mode of o	lying, such as cardiac or re	spiratory arrest,	,	Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition	a I.YMPHOMA					Oriset and Death
4	/Medical Examiner		resulting in death)	Due to (or as a consequen	nce of):				
Н	LAGITITIE	بد	Sequentially list conditions,	b. Due to (or as a consequen	ace off:				
	ed sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a consequen	ice oi).				
	xecut and II-trar	xan	that initiated events resulting in death) Last	c Due to (or as a consequen	nce of):				
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687	ficate g phys	edic							
Box	that the death certificated by the attending properties as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnancy				23d. Date of delive	iry
	death e atte d for	icia	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 2 ☐ Fetal de 4 ☐ Pregnant at time of deat				Month	Day Year
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	requires that the een signed by th nould be detache	by P	Part II. Other significant conditions	contributing to death but not resulting	ng in the underlying cause	given in Part I.		use contribute to th	
rd	w require been sign	ed					1 🗌 Yes	2 No 3 Prob	ably 4 Unknown
Records,	aw as b	Completed					24a. Was an autopsy	prior to cor	psy findings available mpletion of cause of
A.	The late has page	E O					performed? 1 ☐ Yes 2 🛣 N		2 🗌 No
Vital	ysicien: This certificate	Be (25. Was case referred to medical examiner?			26. Place of Death (C.	heck only one)		
)t	y S	မ	1 Yes 2 No		VOutpatient 3 DOA			6 NOther (Specify	HOSPICE
ū		ion	27. Manner of Death 1 Natural 5 Pending	(Month, Day Year)	Bb. Time of 28c. In V	njury at 28d. Vork? □ Yes 2 □ No	Describe how inj	ury occurred	
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Division of	or Al after Direc in by	Certification:	4 Homicide determine	building, etc. (Specify)	o, lami, street, lactory, one		City or Town, Sta	tθ)	, , , , , , , , , , , , , , , , , , , ,
	lospital hours a uneral I		29a. Certifier 1 ▼ Certifying I	Physician: To the best of my knowle	edge, death occurred at the	a time, date and place, and	due to the cause	s) and manner as st	lated.
	P F Ble	edical	(Check only 2 Medical Ex-	Physician: To the best of my knowle aminer: On the basis of examination and manner stated.	n and/or investigation, in m	y opinion, death occurred a	at the time, date a	nd place, and due to	the cause(s)
	within 2 To the comple	Me	29b. Signature and title of certifier	4	29c. Lic	ense number	29d. D	ate signed (Month,	Day, Year)
	->-0) /n'		T)43725		1/19/0	4
	101		30. Name and address of person wh	o completed cause of death (Item 2)	3a) (Type, Print)	3,-3		/ //	/
,	10		DR. TARIQ MAHM	OOD 2300 DULANE	Y VALLEY RD.	TIMONIUM,	MD 21093		
\		ate	31. Date filed (Month, Day, Year)	32. Røgistrar's Signatur	of fra	61			
	Regist	rar	NOV 2 2 2	004	In whom				

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NOVEMBER 19, 2004

ALANTE DEVITO

	1	For State Registrar	State of M		artment of Health			200	Ļ	368	88
		Decedent's Name (First, Middle)	Last)			2.	. Date of Death Month	Day	Year	3. Time of	
Physicia /Medica	al -	Pauline	L.	Denkir	1es 4b. City, Town, or Locatio		OVEMBER		2004	9:41	Рм
Examine	er	4a. Facility Name (If not institution, Saint Josep	h Medical	Center		Towsor		E	alt	imore	
Funeral Director		214-24-5738	6. Sex 7. Ag	e (In yrs. last birthday) 87 Yrs.	If Under 1 Year If Und Months Days Hours	der 24 Hrs. 8. 's Min.	Date of Birth (Month, Day, Yellow)	^(ear) 1917		lace (State o try) N	r Foreign
within /2 nouts after obatin with the Maryland than "natural", or flems 23a or 28a-f show na Wedical Ever a ref mark be tedified at	-	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	ocation				1	0d. Inside C	ity Limits
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B or 28	Direc	10e. Street and Number 3503 Sollers Po	int Road		10f. Zip Code 21222		10g	. Citizen of W	hat Coun	try?	
it of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, it a Medical Eval. and must be redified at	Funeral Director	11. Marital Status 1 □ Never Married 2 □ Marri	12. Was Decedent Armed Forces?	'	Was Decedent of Hispanic (If Yes, specify Cuban, Mexic	Origin? (Specifican, Puerto Ric	fy Yes or No- can, etc.)	14. Race	k, White,		
tural, or	2	3 X Widowed 4 □ Divorced	Year or Dates:	53	1 ☐ Yes 2X No Speci	eify:	16	Specify.		ite	
han "na a Medic	Completed	(Specify only highes Elementary/Secondary (0-12)	college (1-4or	(Give life.	kind of work done during m DO NOT use retired)	nost of working				,	
Hygie thert int,		9 years 17. Father's Name (First, Middle, I	.ast)	Hous	sewife 18. Mo	other's Name (F	First, Middle, Ma	Own H			
arked of	To Be	Shirley Brady			Nan	cy Bark	ær				
27 is mart		19a. Informant's Name/Relationsh James T. Denkin			ng Address (Street and Nun Voodbridge Ce						
If item or other		20a. Method of Disposition 1X Burial 2 ☐ Cremation	3 □Removal from State		osition (Name of matory or other place)	Novemb	œr	c. Location -			
Important: If i any injury or once.	1	4 □ Donation 5 □ Other (Sp. 21 Signature of Fulleral Service I			ill Memorial 2 Name and Address of Fa Connelly Fune	23, 2 eral Hon		Middle Indalk,	P.A.		
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sician		23a. Part 1 Enter the disease, or hock, or heart failure. List Immedia e Cause (Final disease or condition resulting in death)	only one cause on each I	STOKE	ter the mode of dying, such	as cardiac or r	espiratory arres	ι,		Interval Bet Onset and	ween Death
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the attendir	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown		2 Fetal death 3	□Ectopic pregnancy □ Other (specify)			23d. Date Mor	e of delive oth	-	Year
e do	þ	Part II. Other significant condition	ns contributing to death	out not resulting in the t	underlying cause given in Pa	art I.	23e. Did toba		ibute to th		death? Jnknown
cate has been si page 2 should b	Completed	SEPTIC SHOCK					24a. Was an autopsy performe	24b. V	Vere auto rior to cor eath?	psy findings	available ause of
certificate rector, pag	Be Co	25. Was case referred to medical			26. Pl	lace of Death (1 ☐ Yes 24 Check only one)			2 NO	
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r: After the funeral		27. Manner of Death 1 X Natural 2 ☐ Accident 5 ☐ Pendin investig		ury 28b. Time o ay Year) Injury	of 28c, Injury at Work? M 1 ☐ Yes 2		d. Describe how	injury occurr	ed		
within 24 nours arist desith. To the Funeral Director: After this certifica completely filled in by the funeral director, I	Certification:	3 ☐ Suicide 6 ☐ Could r 4 ☐ Homicide determ	not be ined 28e. Place of In building, e	jury - At home, farm, si tc. <i>(Specify)</i>	treet, factory, office	28	f. Location (Stre City or Town,		er or Rura	l Route Num	nber,
Funeral etely filler	edical C			of examination and/or in	th occurred at the time, date nvestigation, in my opinion, o						5)
within 24 hi To the Fur completely	Me	29b. Signature and title of certifie			29c. License numbe	er		1. Date signed	•		
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In		30. Name and address of person		death (Item 23a) (Type	, Print)	T Cil.ir	COM NO	ADVE AN	17) -	1-2004	
() Sta	te	A. HAYID GHI 31. Date filed (Month, Day, Year)	32, Regist	rar's Signature	JOLEK DRIVE	. IUWS	BON, MA	TRYL-HI	YLV E	TERM	
Registr		NOV 2 2 2	104 Selver	na B	South						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienes Reg. No. 2004 36889 Certificate of Death 2. Date of Death Month 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year 43AM m a 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Howard NUTSING Home Columbia Lorien Under 1 Year If Under 24 Hrs. onths Days Hours Min. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Day, Year) 6. Sex 5. Social Security Number Hours Months 1□M 2XF 82 02/12/1922 Virginia 231-12-0330 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 Yes 2000 Howard Columbia 10g, Citizen of What Country? 10e. Street and Number 10f. Zip Code 21044 USA 6334 Cedar Lane 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes XXNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes XX No Specify: Specify: White **¾** Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Day Care 11 Teacher 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Robert Sims Margaret Hubbard 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Sleppy Hollow Court Stockbridge, GA 30281
Disposition (Name of Date 20c. Location - City or Town, State Kenneth Davidson/son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition XXBurial 2 Cremation 3XXemoval from State Oakwood Cemetery 11/20/04 Richmond, VA 22. Name and Address of Facility Witzke Funeral Homes, Inc. 21. Signature of Funeral Service Licensee 5555 Twin Knolls RD, Columbia, MD 21045 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death tailure one year

Priysician /Medical Examiner

Physician

/Medical

Examiner

10a. State

MD

ក្ន Direct

Funeral

Completed

Funeral

Director

I show

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Importent: If Item 27 is marked other than "natural", or Items 23a or 28a-1 show any injury or other traumatic event, It's Mydical Executer invat be notified at

Baltimore, Maryland 21215-0036

attending physician and for use as the burial-transit The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760. Physician/Medical 2 Completed

After this certific funeral director. s after death. filled in by Hospital or 24 hours

Be

Certification: To

Medical

Immediate Cause (Final disease or condition resulting in death) chronic renal Due to (or as a consequence of) years Hupertension Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day Year

5 Other (specify)

State Registrar

NOV 2 2 2004

30. Name and address of person who co

in the past 12 months? 1 ☐ Yes 2 No

Coronary

Atrial

25. Was case referred to medical

1 ☐ Yes 2 No

examiner?

27. Manner of Death

Natural 2 Accident

3 ☐ Suicide

29a. Certifier

4 Homicide

(Check only one)

29b. Signature and title of certifier

Dementia

5 Pending investigation

6 Could not be determined

Li

10780 HICKORY

eted cause of death (Item 23a) (Type, Print)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

miD.

4 Pregnant at time of death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

artery

fibrillation

28a. Date of Injury (Month, Day Year)

9 Unknown

D56531

1 ☐ Yes 2 ☐ No

28c. Injury at Work?

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

23e. Did tobacco use contribute to the cause of death?

24a. Was an autopsy perform

1 ☐ Yes

Other: 4X Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred

26. Place of Death (Check only one)

1 Yes 2 No 3 Probably 4 Unknown

1 Tyes

24b. Were autopsy findings available prior to completion of cause of death?

2X No

NOV 17, 2004

Ridge Road, Columbia, MD 21044

within 2 To the I

			1 _ For		State of Ma	aryland		artment o rtificate o			ental Hy	•	150		
			Registrar 1. Decedent's N	lame (First, Middle, Las	t)		00.	incate	Deal	.11	2. Date of De	Reg. Ne	nne	1	3 1500 P1011
	Physici		Mary		Dickinson						Month	Da		004	1 724M
	/Medic Examir			e (If not institution, give				4b. City, Tow	n, or Locatio	on of Death	NOV	4	c. County of		1.33A
1	Exami	iei	St. Agi	.1	Car 900	Caton	Ave	Rolf	i.				n/2	Dodgii	
	Funeral		5. Social Seouri			e (In yrs. la	st birthday)	If Under 1 Ye	ar If Und	ler 24 Hrs.	8. Date of Bi	rth	. 9). Birthpl	ace (State or Foreign
п	Director		578-01-0	527	□M 2 🖁 F	93	Yrs.	Months Da	ys Hour	s Min.	8. Date of Bi (Month, Di Septembe	ay, Year 22	, 1911	Count	nsylvania
	P _		Usual Residence												
	farylan show	-	10a. State	10b. County			Town or Lo							10	Od. Inside City Limits
	Be-f.s	cto	MD	Baltim	ore	Ca	atonsvi	11e							1 Yes 2 No
	iff th	Dire	10e. Street and	Number				10f. Zip Cod	le			10g. C	itizen of Wh	at Count	try?
	ath w	rai	713 Mai	den Choice La				2122					USA		
	er de	Funeral Director	11. Marital State		12. Was Decedent Armed Forces?		13.	Was Decedent	of Hispanic (Cuban, Mexic	Origin? (Spe can, Puerto f	cify Yes or No Rican, etc.)	0-	14. Race - Black,	America White, e	
36	s afte	by F		Married 2 Married ed 4 Divorced	1 ☐ Yes 2 ☐X	No		1 ☐ Yes 2 ☐ 1					Specify:	Whit	-0
5-0036	72 hours after death with the Maryland natural', or items 23e or 28e-f show dical Evanting frout be notified at		3 7 11100111	15. Decedent's Ed	Year or Dates:		16a Dece	dent's Usual Oc	cupation			16h 4	Cind of Busin		
15	in 72 in 72	Completed		Specify only highest gra	de completed)		(Give	kind of work do DO NOT use re	ne during m tired)	ost of working	ng	10D. F	Kind of Busin	iess/ind	ustry
12	within iene. r then "	E O	Elementary/S	Secondary (0-12)	College (1-4or 5	5+)		utician	·			R	eautv/H	air	
D	filed Hyg other	Be C	17. Father's Na	me (First, Middle, Last)				u o i o i a i i	18. Mo	ther's Name	(First, Middle			un	
<u>a</u>	ld be ental ked ic ev	To B	Joseph	H. Tr	rader				Ka	atherine	2		Farnon		
Maryland 2121	12 should be filed within h and Mental Hygiene. 7 Is marked other then " raumatic event, the Mes	-		s Name/Relationship (7	ype, Print)		19b. Mailir	ng Address (Str				er, City		ate, Zip (Code)
	s 1 and 2 should be filed within 72 hours after death with the Maryla Health and Mental Hygiene. Item 27 Is marked other then "natural", or Items 23e or 28e-f show other traumatic event, the Medical Examinar must be rediffed at		Jeanne M	. Lindsay—Moor	e-cousin		460	9 Valley	View A	venue, I	3altimor	e, M	2120	6	
Baltimore,	pernit. Pages 1 and Depritment of Health Importent: If item 27 any njury or other to once.		20a. Method of	,		20b. Pla	ce of Dispo	sition (Name of natory or other	•		ate	_	ocation - Cit		vn, State
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Ħ	permit. Pag Department Importent: I any njury o	ļ		f Funeral Service Lice				2. Name and Ad							al Home
Ä	Depermine Deperment of the series of the ser		1/1	1111			5	305 Harfo	ord Rd.	, Baltir	more, MD	212	214	u C	at none
			23a. Part1. Ent	er the disease, or comp	lications that caused	the death.									Approximate
	Physician		Immediate Cau		one cause on each III	16. January		· / in	1	L'an					Interval Between Onset and Death
	/Medical		disease or con- resulting in dea		a Due to (or as	a conseque	ence of:	ial en	wici	1) 000					3 days
	Examiner				. (OUNT	AtiVA	ial in Hear	et la	ilar					I rear.
		ē	Sequentially lis	o utilitiediate	Due to (cr as	a sonseque	ence of):	LHW	1						
Vi	be executed sician and burial-transit	Examiner	cause. Enter U Cause (Disease that initiated ev	e or injury	c.										
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	dea he att	sici	1 🗆 Yes		4☐ Pregnant at			Other (specify,					Month		Day Year
P.0	that the de led by the a detached t	Phy	9 🗆 Unkno								-				
	res tha igned be del	by	Part II. Other si	gnificant conditions of		ut not result	ting in the u	nderlying cause	given in Par	rt I.					cause of death?
ord	w requir been si should	ted		rneumon.	. A						1 🗇	Yes 2	□No 3[] Probai	bly t Unknown
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/ita	Physicien: Th this certificate ral director, paç	Be (25. Was case re examiner?	eferred to medical					26. Pla	ce of Death	(Check only o	one)			
) t	99	၉	1 Tes	26 100	Hospital: 1 Inpatie		R/Outpatien	t 3 DOA	Other: 4 🗆 i	Nursing Hom	e 5 ☐ Resi	dence	6 ☐Other (Specify)	
	ng P	on:	27. Manner of D	eath 5 Pending	28a. Date of Inju- (Month, Day	Year) 2	8b. Time of Injury	28c. Ir V	njury at Vork?	28	8d. Describe i	how inju	ry occurred		
Division	il or Attending Phy after death. Director: After this I in by the funeral of	Certification:	2 Accider						☐ Yes 2[
Ĭ.	or At fter d pirect n by	riii	4 🗍 Homici	al a t a section and	28e. Place of Inju- building, etc	ury - At hom :. (Specify)	ne, tarm, str	eet, tactory, office	ce	21	Bt. Location (: City or To	Street ar wn, State	nd Number o e)	r Rural I	Route Number,
	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the funer		00- 0	ND	-1-1	, .									
	To the Hospitel within 24 hours a To the Funerel Completely filled	Medical	29a. Certifier (Check only one)	2☐ Medical Exam	sician: To the best of iner: On the basis of	examination	ledge, death on and/or inv	n occurred at the restigation, in m	e time, date a y opinion, de	and place, ar eath occurre	nd due to the d at the time,	cause(s date and) and manne d place, and	er as stat due to t	ted. he cause(s)
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			1 - For State	State of I	Maryland / Dep	artment of F		-	giene Reg. No D D	1 00001
			Registrar 1. Decedent's Name (First, Midd	fle, Last)		Timouto or	Journ	2. Date of Dea	البياد البياد البيادا	3. Time of Death
	Physici		John Me	agher Dono	ghue			Month Novembe		9ar 14 12:55 P M
	/Medio Examin		4a. Facility Name (If not institution		<u> </u>	4b. City, Town, o	r Location of Death		4c. County of [
			Suburban	Hospital		Beth			Montgo	mery
	Funeral		5. Social Security Number	6. Sex 7. 1⊠ M 2□ F	Age (In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Day	y, Year)	Birthplace (State or Foreign Country)
	Director		477-56-2406 Usual Residence of Decedent	A COL	52 Yrs.			June 16	, 1952 Mi	nnesota
	land ow		10a. State 10b. Count	у	10c. City, Town or Le	ocation			-	10d. Inside City Limits
	Man B-1 sh	to	Maryland Monts	gomery	Bethesd	a				1 ☐ Yes 2X No
	or 28)jrec	10e. Street and Number			10f. Zip Code			10g. Citizen of Wha	at Country?
	ath wi	rai	7714 Marykno	11 Avenue			20817		United S	tates
336	ges 1 and 2 should be filed within 72 hours after death with the Maryland 1 of Health and Mental Hygiene. If item 27 is marked other then "neturel", or Items 23e or 28e-1 show or other treumatic event, the Medical Evant retreumatic event, the Medical Evant retreumatic event.	by Funeral Director	11. Marital Status 1 □ Never Married 2 ☑ Ma 3 □ Widowed 4 □ Divorce	If Yes, Give	⊠ No	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2X No	ispanic Origin? (Spe in, Mexican, Puerto I Specify:	ecify Yes or No- Rican, etc.)	14. Race - A Black, V Specify:	American Indian, White, etc. White
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re,	s 1 and 3 f Health item 27 other tr		20a. Method of Disposition		20b. Place of Dispo		D		20c. Location - City	
m	Pages nent of thint: If ite ury or of		1 ☐ Burial 2 ☐ Cremation 1 ☐ Donation 5 ☐ Other (gomery ium, inc.	20, 2	2007	Bethesda,	Marvland
Baltimore,	permit. Pages Department of Importent: If it any injury or once.		21. Signature of Funeral Service	Licensee Stars	M01356	Z. Name and Address thesda-Ch Bet	ss of Facility Robe levy Chase hesda, M	ert A. , Inc., aryland	Pumphrey 7557 Wis 20814-3	Funeral Home/ consin Avenue 3501
			23a. Part1. Enter the disease, of shock, or heart failure. Lis	or complications that caust only one cause on each	sed the death. Do not en					Approximate Interval Between
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н	Examiner	_	Sequentially list conditions,	b		-				
	ed sit	njne	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	10) 0; eud	as a consequence or):					
	ficate be executed physician and s the burial-transit	Examiner	that initiated events resulting in death) Last	c. Due to (or	as a consequence of):			_		
8760,	siciar burit	dical E								
9	tificate g phy as the	Φ.		u						
D. Box	The law requires that the death certific thas been signed by the attending page 2 should be detached for use as:	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		n 2 ☐ Fetal death 3[t at time of death 5[Ectopic pregnancy Other (specify)			23d. Date of Month	delivery Day Year
P.0	es that the de gned by the a be detached f		Part II. Other significant condit	ions contributing to deat	h but not resulting in the u	nderlying cause give	en in Part I.	23e. Did to	bacco use contribut	te to the cause of death?
Records,	uires sign Id be	d by			_			1 🗆 Y	′es 2 □ No 3 □	Probably 4 Unknown
00	w requir s been si should	Completed			_	-		24a. Was a	an 24b. Wer	e autopsy findings available
Be	The law cate has page 2 s	E O						autop	sy prior med? deat	to completion of cause of h?
Vital	(G CT	O	25. Was case referred to medic	al			26. Place of Death		2 No 1 1 1	res 21 No
of V	Physicien: this certificaral director, i	To B	examiner? 1 XYes 2 ☐ No	Hospital:	atient 2 ER/Outpatie	nt 3□ DOA Dthe	^{эг:} 4 □ Nursing Hoл	ne 5 🗆 Resid	ence 6 Other (S	Specify)
ПО	ding Pl n. After the		27. Manner of Death 1 Natural 5 □ Pend	28a. Date of I (Month,	njury 28b. Time o Day Year) Injury	Worl	ς?	8d. Describe h	ow injury occurred	
Sio	Attending or death. ector: After by the fune	cati	2 Accident inves	tigation			Yes 2 □ No			_
Division	oitel or Attendurs after deathurs after deathurel Director:	Certification:	4 Homicide deter	mined 286. Place of building,	Injury - At home, farm, st etc. (Specify)		1	City or Tow	n, State)	r Rural Route Number,
	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certific completely filled in by the funeral director.	Medical	(Check only 2 Medica	I Examiner: On the basis	est of my knowledge, deat s of examination and/or in stated.	vestigation, in my of	pinion, death occurre	ed at the time, o	date and place, and	due to the cause(s)
•	7 wit	4	29b. Signature and title of certifit	- M		29c. License	30027	2	29d. Date signed (M	- OY
_	0		Name and address of person	8600 O	-D CONSES		Bones	DA M	805 d	14'
1	Sta Registr		31. Date filed (Month, Day, Yea.	2 2 2004 N	strar's Signature	1 5	· •.			
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Donoghue, John 1111104 12:35 Pm

1. Decedent's Name (First, Middle, Last) A. Facility Name (If not institution, give street and number) A. Facility Number (If not institution, give street and number) A. Social Security Number (S. Sex 213-16-3493) A. Social Security Number (If not institution, give street and number) A. Social Security Number (If not institution, give street and number) A. Social Security Number (If not institution, give street and number) A. Social Security Number (If not institution, give street and number) A. County of Death (It Under 1 Year If Under 1 Year If Under 24 Hrs. (Month, Day, Year) Apr 17, 1912 Maryland Apr 17, 1912 Maryland I. Decedent's Name (First, Middle, Last) A. Time of Death 1:50 A A. Social Security Number (If not institution, give street and number) A. Social Security Number (If not institution, give street and number) A. Social Security Number (If not institution, give street and number) A. Social Security Number (If not institution, give street and number) A. Social Security Number (If not institution, give street and number) A. Social Security Number (If not institution, give street and number) A. Social Security Number (If not institution, give street and number) A. Social Security Number (If not institution, give street and number) A. Social Security Number (If not institution, give street and number) A. Social Security Number (If not institution, give street and number) A. Social Security Number (If not institution, give street and number) A. Social Security Number (If not institution, give street and number) A. Social Security Number (If not institution, give street and number) A. Social Security Number (If not institution, give street and number) A. Social Security Number (If not institution, give street and number) A. Social Security Number (If not institution, give street and number) A. Social Security Number (If not institution, give street and number) A. Social Security Number (If not institution, give street and number) A. Social Security Number (If not institut			For State Registrar	Otate of W	aryland / Dep <i>Ce</i>	ertificate of		-	Reg. No. 00	4 36892
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Temporary The Color The			400 Georgia Cour			21204			United S	tates
Toward Companies College Col		nue	/	Armed Forces?		. Was Decedent of I If Yes, specify Cub	Hispanic Origin? (Spean, Mexican, Puerto	ecify Yes or No Rican, etc.)	- 14. Race - Black,	
15. Michaer's Name (First, Middle, Master Symame) 15. Michaer's Na				If Yes, Give	No	1 ☐ Yes 2 ☑ No	Specify:		Specify:	
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Say Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate information and beath of the cause o			`4 □Donation 5 □Other (Spe	ecify)	Chesapea		cory 2	004		
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State

1. Date filed (Month, Day Year) NOV 2 0 2004

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Lenter on. Weener of For N. Charles St, Scale 4205 y. Hhan, no 2/109

			T = For State Registrar	State of Ma	aryland /		artment of F tificate of		nd Mental Hy	/gien Reg. No	/ 1111/3	36893
	Physici	an	1. Decedent's Name (First, Middle, Last,	/ _ /	C. 1	5/			2. Date of D	Da		3. Time of Death
	/Medic	al	4a. Facility Name (If not institution, give		rank	, ,		al austine of F	Nov		· / , m	04 15:18 M
	Examir	er	Union Hospital of		inty		4b. City, Town, o	Elkton	Death		c. County of Dea ecil	ın
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L	Director		219-30-3571	M 2□F	68	Yrs.	Months Days	Hours	Min. (Month, D Jan 8,	193	6 Mar	cyland
	and w		Usual Residence of Decedent 10a. State 10b. County		10c. City, To	own or Lo	cation					10d. Inside City Limits
	Maryl -f sho	tor	MD Cecil		Elkto	n						1 ☐ Yes 2 ☑ No
	n the	Director	10e. Street and Number		DIREC		10f. Zip Code			10g. Ci	itizen of What Co	ountry?
	th wit		19 Seminary Lane				21921			Uni	ted Sta	tes
Maryland 21215-0036	72 hours after death with the Maryland "netural", or Items 23e or 28e-f show oldes! Examirer must be notilited at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 Yes 2 In If Yes, Give Year or Dates:	-	1	Vas Decedent of H Yes, specify Cuba	lispanic Origin an, Mexican, F Specify:	? (Specify Yes or Nouerto Rican, etc.)	0-	14. Race - Ame Black, Whit Specify: Whit	e, etc.
2-0	hin 72 ho e. an "netur	ted	15. Decedent's Edu (Specify only highest grade	cation	16	Sa. Deced	ent's Usual Occup	ation	fandrina	16b. F	(ind of Business	
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and		o Be	Samuel DeFrank					Anna	Name (First, Middle Dalesio	, Maider	n Surname)	
IZ.	2 should be and Mental is marked o	^L	19a. Informant's Name/Relationship (Ty	oe, Print)	1:	9b. Mailin	g Address (Street		or Rural Route Numb	er. City	or Town, State.	Zio Code)
	1 and 2 Health a tem 27 is		Mrs. E. Joann DeFr	ank, Sr.								-,,
Baltimore,	Pages 1 annent of Heanant: If Item		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	ceme	tery, crem	sition (Name of latory or other place ce Cremat		Date Nov 20 2004		ocation - City or	
Baltii	permit. Pages Department of Important: If I any injury or o		21. Signature of Funeral Service License	el N	48984	22 C	Name and Addre	ss of Facility	uneral Altures Drive	tern		
San London	Pnysician /Medical Examiner	Examiner	23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underfying Cause (Disease or injury that initiated events	Due to (or as	a contequence	e of):	4 2 n f	5.97		irrest,		Approximate Interval Between Onset and Death I m m advicte
68760,	tificate be executed ig physician and as the burial-transit	edical Exa	resulting in death) Last	Due to (or as	a consequenc	e of):						
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	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical C	29a. Certifier (Check only one) 1 Certifying Phys 2 Medicel Examin	ician: To the best of er: On the basis of and manner sta	examination a	ge, death and/or inv	occurred at the timestigation, in my op	ne, date and pl pinion, death o	lace, and due to the occurred at the time,	cause(s) date and	and manner as d place, and due	stated. to the cause(s)
)	To Toom	2	29b. Signature and title of certifier Harlos	mg			29c. License	3 /4			te signed (Month	
10	77 -		30. Name and address of person who co	lh	ath (Item 23a	HUSP	Ital, E	= 1kto	n, M			
	Sta Registr		NOV 2 0 2004	September 1	13 Signature		sands					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 36894 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month 2000 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death ente If Under 1 Year ALTIMORE lencest If Under 24 Hrs. **Funeral** 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Hours 1□M 20 F 219-20-955 November Director ILANDA Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits other treumatic event, the Medical Examinar must be notified at Be Completed by Funeral Director 1 ☐ Yes 2 No RKVIL 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 2123 or items 23a DIOLE 12. Was Decedent Ev.
Amed Forces?
1 Yes 2 No
If Yes, Give
Year or Dates: 11. Marital Status Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Department of Health and Mental Hygiene. Importent: If item 27 is marked other then Elementary/Secondary (0-12) College (1-4or 5+) menaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Kaasdal 19a. Informant's Name/Relation of (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8203 MD21234 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Pages 1 1 Burial 2 Cremation 3 Removal from State ŏ 11-19-04 injury ⁴ □ Donation 5 □ Other (Specify) 22. Name and Address Facility PALTIMORE, MD 21. Signatury of Funeral Service License any ir 23a. Part1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause of each line. EVANS FUNERALCHAPEL Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Finat disease or condition resulting in death) **Physician** Concer Ung 10ans /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Hospitel or Attending Physicien: The law requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 4☐Pregnant at time of death Month Dav Year 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Cther: 4 Nursing Home 5 Residence 6 Other (Specify) 0 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 050160 28a. Date of Injury (Month, Day Year) 27. Manner of Death Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Natural Accident Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation after death Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours a To the Funerel D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature appl title of certifier 29c. License number 29d, Date signed (Month, Day, Year) 1)25205 Why in 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GBM 6701 N. Charles St. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State som Kal Registrar DHMH 17 Rev 1/2001

ORIGINAL

		1- State Unpend Item	23a,pt.11	,27,28a-f	artment per me <i>rtificate</i>	of L	Death	-23	04 tas	giene Reg. No	2001	368
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/Med		Andrew James Fo							Novemb		5, 200	
Exami	ner	4a. Facility Name (If not institution, give)	4b. City, To	own, or	Location o	f Death		4c.	County of D	eath
		101 S. Dean Stree 5. Social Security Number 6. Se		ge (In yrs. last birthday	Balti If Under 1		e If Under 2	14 Hea	T = 1 = 1 = 1			
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r 28a-f show	Director	10e. Street and Number		Daiti	10f. Zip C	Code				10a Citi	zen of What	1X Yes 2
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	by	1 Never Married 2 Married 3 Widowed 4 Divorced	1 Tes 2 X If Yes, Give Year or Dates:	No	ir res, specing 1 ☐ Yes 2		, Mexican, Specify:	Puerto	Hican, etc.)		Black, W Specify:	hite, etc. white
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12 shour and M	-	19a. Informant's Name/Relationship (7)					nd Number	or Rura	l Route Numb	er, City or	Town, State	, Zip Code)
C = (4 F		Mary Fowler/mothe 20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ F	Removal from State	20b. Place of Dispo cemetery, crea	sition (Name	of			Ltimore Date		2122 cation - City	4 or Town, State
permit. Pages 1 ar Department of Hea Important: If item any injury or othe		4 □ Donation 5 ☒ Other (Specify) 21 Signature of Funeral Service Licens ROnald S		2:	Name and λ	Address	of Facility	ard	655 M	D - 1		G.
70 E 8 9	Н	23a. Part1. Enter the disease, or comp	100	the death. Do not on	Itimoi	re,	MĎ ^D 2	120	1 033 W.	ват	timore	Street
Physician /Medical Examiner		nock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	a Alcohol	Intoxicati a consequence of):					Trospiratory at			Approximate Interval Betwe Onset and Dea
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	Completed							_	24a. Was a autop perfor Yes	sy	24b. Were a prior to death?	autopsy findings ava completion of caus s 2 \(\text{No} \)
icien: Sertific ector,		25. Was case referred to medical examiner?				2	6. Place o	f Death	(Check only or			
Physicien: this certific ral director,	2	XX 65 Z	lospital: 1 Inpatie			Other:	4 Nuis	ing Hom	e 5 🗀 Resid	ence 6	Other (Sp.	ecify)At scer
ing After uner	ion	27. Manner of Death 1 □Natural 5 □ Pending	Found:	Year) Folium		Injury a Work?	t	2	8d. Describe h	ow injury	occurred	
Attending It death. ector: After by the fune	icat	2 Accident investigation 3 Suicide 6 Could not be	11-5-200	04 5:00	P ^M		s 2 X No		nknown			
2 = 2	Certification:	4 Homicide determined	building, etc		et, factory, of	ffice						Pural Route Number Dean St
Hospite 24 hours Funera tely fille	edical C	29a. Certifier 1 Certifying Phys (Check only one) 2 Medicel Examin	sician: To the best of	of my knowledge, death examination and/or inv	occurred at the	he time, my opin	date and l	olano a	altimon and due to the cold at the time, d			6
To the within 2 To the comple		29b. Signature and title of certifier	and manner ste	illed.		icense n						th, Day, Year)
F= ≤ F= Ö		> Zalriul			0.	.C.M						5, 2004
		30. Name and address of person who co	mpleted cause of de	(imore,			
					Dan-							

State of Maryland / Department of Health and Mental Hygien 200136896 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Betty Ann Flickinger November 20, 2004 2:16 PM /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Rockville
If Under 1 Year | If Under 24 Hrs. Shady Grove Adventist Hospital Montgomery 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. 1 ☐ M 2 🂢 F Director 216-44-6763 Hawaii Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits 28a-f shov traumatic event, if a Medical Examinational be notified at 1 ☐ Yes 2 No Director <u>Maryland</u> Montgomery Wheaton 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 0 Itams 23a 20902 <u>2004 Arcola Avenue</u> United States Completed by Funeral death permit. Pages 1 and 2 should be filed within 72 hours after deal Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" ~ " any injury or other traumatic even." 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🔯 No Specify: Specify. White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) United States 5+ Grants Administrator Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 2 Jodie Edward Ashmore <u>Harriet Easton Ware</u> 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Sheldon T. Nutter/ Guardian 2000 Arcola Avenue Wheaton, Maryland 20902 20b. Place of Disposition (Name of cemetery, crematory or other place)
Parklawn 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State November 24, 2004 `4 ☐ Donation 5 ☐ Other (Specify) Park Memorial Rockville, Maryland 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase. Inc. 7557 Wisconsin Avenue Bethesda, Maryland 20814-3501 21. Signature of Funeral Service Licensee M00335 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CARCINOMA OF HYPOPHARYNX **Physician** SUMMOUS CELL MONTH disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-transit The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of) Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 DEctopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. 1 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ funeral director, page 2 should be 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2☐ No 24a. Was an 2FINO 1 ☐ Yes Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) examiner Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Tyes 1-Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Injury 1- Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation death. after death 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a To the Funeral D 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier NOVEMBER 20 KUNOVIUG, MD P. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) #208 ROCKVILLS MA 11125 KURUVIUG 32. Registrar's Signature State NOV 2 2 2004 Registrar

State of Maryland / Department of Health and Mental Hygiene 004 36897 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** GREEN NOVEMBER 2004 02:00 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MEDICAL CENTER Baltimore 5. Social Security Number Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Funeral 9. Birthplace (State or Foreign 1 □ M 2 7 F Months Days Hours 250.38.4612 T. M29 SOUTH CAROLINA Director Usual Residence of Decedent with the Maryland 10a. State 10b County 10c. City, Town or Location If item 27 is marked other than "natural", or items 23a or 28a-f show or other treumstic event, it a Modical Examinar must be notified at 10d. Inside City Limits MD ALTIMORE 1 Yes 2 □ No Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death v Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian filed within 72 hours after 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married 3altimore, Maryland 21215-0036 1 Yes 2 No Specify 3 Widowed 4 Divorced Specify: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 72.
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "na any injury or other treumatic event, It a Mustice. Elementary/Secondary (0-12) College (1-4or 5+) DOMESTIC DRIVATE 17. Father's Name (First, Middle, Last) Mother's Name (First, Middle, Maiden Sumame) BRIGHTMAN -LIJAH 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Num GRINDON DAVEHTEK DENISE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1 ØBurial 2 ☐ Cremation 3 ☐ Removal from State BACT, MORE, MAZYLAND 1 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee MARYLAND 21212 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) PULMONARY EMBOUSM Prysician /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner certificate be exec Due to (or as a consequence of): P.O. Box 68760, been signed by the attending physician should be detached for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Dav Year 4 Pregnant at time of death 5 Other (specify) 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, DISEASE CORONARY HOART 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Munknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a Was an autopsy this certificate 2**X** No Yes Be 25. Was case referred to medical examiner? 26. Place of Death Check onl one Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural
2 Accident 5 Pending investigation 1 🗌 Yes 2 No To the Hospitel or Attend within 24 hours after death To the Funerel Director: A 3 🗍 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Thomicide Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number November 19, 2004 MASCOD. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
SYED O, MASCOD, M.D., 4940 EASTERI 4940 BALTIMORE MD, 21224 EASTERN AVENUE 31. Date filed (Month, Day, Year) 32. Registrar's Signature State NOV 2 2 2004 Registrar

			1 - State of Maryland /		artment of Health and rtificate of Death		ene 001	36898
	Physici /Medi		Decedent's Name (First, Middle, Last) Marlyn A. God	win		2. Date of Death Month Novembe	Day Year 14,2004	3. Time of Death
	Examir	er	4a. Facility Name (If not institution, give street and number) Maryland Masonic Home		4b. City, Town, or Location of Dec Cockeysville		4c. County of D Balt	eath Limore
	Funeral Director		5. Social Security Number 6. Sex 1 M 2 1 F 7. Age (In yrs. last II Usual Residence of Decedent	Yrs.	If Under 1 Year If Under 24 Hours Min		rear)	Birthplace (State or Foreign Country) est Virginia
	within 72 hours after death with the Maryland ene. then "natural", or Items 23e or 28e-f show the Medical Exaction to the rectified at	ctor	10a. State 10b. County 10c. City, To	wn or Lo	Parkville			10d. Inside City Limits 1 ☐ Yes 2 🛣 No
	s 23a or 26 oust be no	ral Director	10e. Street and Number 8800 Old Harford Road		10f. Zip Code 21234		g. Citizen of What United St	ates
036	ursafter de al'oritam Enacideer	Completed by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ☒ No If Yes, Give Year or Dates:	- 1	Was Decedent of Hispanic Origin? (If Yes, specify Cuban, Mexican, Pue 1□ Yes 2☑ No Specify:	(Specify Yes or No- erto Rican, etc.)	14. Race - Ai Black, W Specify:	merican Indian, hite, etc. White
21215-0036	ithin 72 ho ne. nan "natur. Medical I	npleted	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0·12) College (1-4or 5+)	(Give	dent's Usual Occupation kind of work done during most of w DO NOT use retired)	rorking	6b. Kind of Busine	
	d be filed wantal Hygier ted other ti c evant, In	Be	12 Years 17. Father's Name (First, Middle, Last) Alva Lantz			ame <i>(First, Middl</i> e, <i>M.</i> Le Vanov	Own Ho aiden Sumame)	ome
Maryland	nd 2 shoul alth and Me 27 is mark ir traumatli	Jo	19a. Informant's Name/Relationship (Type, Print)		g Address (Street and Number or F Brentwood Ave.	-4		
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or Itams 23a or 28a-f show any injury or other traumatic event, the Medical Eracinst to use the notified of ODGs.		PD Burial 2 Cremation 3 Removal from State	ery, cren	sition (Name of natory or other place) In Cemetery 11/1		Oc. Location - City	or Town, State
Balt	permit. Departi Import any inj once.		21. Singlere of Funeral Service Licensee	7	Name and Address of Facility Duda-Ruck Funera 922 Wise Ave. [undalk. Ma	arvland	
i. S.	Physician /Medical		23a. Part1. Enter the disease, or complications that caused the death. Do shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence)	rte		ac or respiratory arres	st,	Approximate Interval Between Onset and Death
	Examiner	ner	Sequentially list conditions, if any, leading to immediate cause. Enter 0 designs 9					
8760,	cate be executed physician and the burial-transit	al Examiner	Cause (Disease or injury that initiated events c. Due to (or as a consequence constitution of the consequence consequence)	of):				-
Box 687	death certificate I e attending physi id for use as the b	n/Medical	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy				23d. Date of d	aliven.
P.O. B	0 0 0	Physician/Me	in the past 12 months? 1 ☐ Yes 2 No 4 ☐ Pregnant at time of death 9 ☐ Unknown 9 ☐ Unknown	5	Ectopic pregnancy Other (specify)		Month	Day Year
ecords,	law requires that the as been signed by the 2 should be detache	þ	Part II. Other significant conditions contributing to death but not resulting Hypertern, Kypelipselerin	in the un	derlying cause given in Part I.		_	to the cause of death? Probably 4 Onknown
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n or	ng Phy fter this	ToB	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/O 27. Manner of Death 28a. Date of Injury 28b.	utpatient Time of Injury	O++	eath (Check only one) Home 5 Residence 28d. Describe how		ecify)
DIVISION	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, f building, etc. (Specify)			City or Town, S	State)	Rural Route Number,
	thin 24 hou thin 24 hou the Funa impletely fil	Medical	29a. Certifier (check only one) 2		200 Liganes aumber	1 004	Data da 100	
	10		30. Name and address of person o completed ca se of death (Item 23a)	(Type 5	DZIXEX	540	Date signed (Mon	0 Y
B	Sta	te.	Robert LiBerto, W. 300 Jule 31. Date filed (Month, Day, Year) 32. Registrar's Signature	rule	and Cer . Core	ressuell,	nig	21030
	Registra		NOV 2 2 2004 Depens	19	Soarke!			

State of Maryland / Department of Health and Mental Hygien 36899 For State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** November 19, 2004 Wilhelmina Granruth 5:45PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner N/A 5306 Hamlet Avenue Baltimore If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 ☐ F 219-28-7574 97 Director Nov.9. Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or tiems 23a or 28a-1 show any injury or other traumatic event, the Medical Expensions. 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 XYes 2 □ No Director MD N/A Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 5306 Hamlet Avenue 21214 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ XNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🗶 No White Specify: Specify: þ 3 Y Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Hame 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Henry Wiegand Lisette Gerlach 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Betty Lou Ellerman- Daughter 5306 Hamlet Avenue Baltimore, Maryland 21214 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Gardens of Faith Cemetery 11/23/04 Baltimore, Maryland 22. Name and Address of Facility Leonard J. Ruck, Inc. 21. Signature of Funeral Service Licensee Heather Cain 5305 Harford Road Baltimore, Maryland 21214 Heatles 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Consi disease or condition resulting in death) /Medical Due to (or as a onsequence of) Examiner Sequentially list conditions, the standard cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed use as the burial-trans attending physician and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month in the past 12 months? Day 4☐Pregnant at time of death 5 ☐ Other (specify) the 9 Unknown 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Dnknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 No 24a. Was an autopsy 2 **N**NO 1 Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other 1 ☐ Yes 2 XNo 4 ☐ Nursing Home 5 MResidence 6 ☐ Other (Specify) Certification: To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After t 1 Natural 2 Accident 5 Pending investigation 1 Tyes 2 No after death Director: 6 ☐ Could not be 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by determined 4 Homicide To the Hospital within 24 hours a To the Funeral E 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29c. License number D 30661 29b. Signature and title of certifier November 20 5 Baltimore, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) roch 5601 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

ORIGINAL

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	Pnysici /Medio	an	1. Decedent's Nam	ne (First, Middle, Last)		Garrett	erincate or	Deain	2. Date of Do Month	Reg. No. Leath Day 29	Year OH	3. Time of Death
	Examir Funeral Director		5. Social Security N 214-36-2	7408 6. Sex	1 Medica	o (In yrs. last birthda 63 Yrs.	SAL		8. Date of Bi (Month, D July 2	rth ay, Year)	9. Birth	
	Maryland f show	tor	Usual Residence of 10a. State MD	10b. County Somerset		10c. City, Town or Westov						10d. Inside City Limits 1 ☐ Yes 2 ☐ No
"	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Ptyglene. Important: If item 27 is marked other than "natural", or Itams 23a or 28a-1 show amy injury or other traumatic avant, the M. diral Examinar roual be notified at ance.	Funeral Director	11. Marital Status	evells Necl	12. Was Decedent Armed Forces? 1 \(\text{Yes} \) 2 \(\text{I} \)			21890 Hispanic Origin? (Sp ban, Mexican, Puerto	pecify Yes or No Rican, etc.)		USA . Race - Amer Black, White	ican Indian,
21215-0036	d within 72 hours a giene. ir than "natural", o	Completed by	3 □Widowed (Spe Elementary/Secunk	15. Decedent's Educify only highest grade	College (1-4or 5	(G	1 ☐ Yes 2 ☑ No cedent's Usual Occurve kind of work done b. DO NOT use retire	ipation	_{king} unk		pecify: W	nite ^{ndustry} unl
Maryland	12 should be filed within h and Mental Hygiene. 7 is marked other than "I reaumatic avant, the Mes	To Be C	17. Father's Name	(First, Middle, Last)			unk	18. Mother's Nam				unk
	ages 1 and 2 short of Health and t: If item 27 is m y or other traum		ECI 20a. Method of Dis	sposition Gremation 3 Statement Green G	emoval from State	304 20b. Place of Dis	•	s Neck Wes		MD 2	own, State, Z 1890 Ition - City or T	
Baltimore,	permit. Pa Departme Important any injury once.				M 0/1.	ector		ress of Facility tomy Board		. Balt	imore	Street
	Physician /Medical Examiner		shock or her Immediate Cause disease or conditi resulting in death)	on f	ne cause on each li	the death. Do not				arrest,		Approximate Interval Between Onsevand Death
68760,	eath certificate be executed attending physician and for use as the burial-transit	Ilcal Examiner	Sequentially list crif any, leading to it cause. Enter Und Cause (Disease of that initiated event resulting in death)	eriying r injury is	Due to (or as	a consequence of):						
O. Box	o o	Physician/Medical	IF FEMALE: 23b. Was deceder in the past 1; 1 ☐ Yes 2 9 ☐ Unknown	nt pregnant 2 months?	3c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal death	3 □Ectopic pregnand 5 □ Other (specify)	су		230	d. Date of deli Month	very Day Year
ords, P.	law requires that the as been signed by th 2 should be detache	by	Part II. Other sign	ificant conditions cor	ntributing to death b	ut not resulting in the	e underlying cause g	iven in Part I.		tobacco use		the cause of death?
Il Records,	The ate ha	Completed							24a. Was auto perf 1 \square Yes	s an 2 ppsy ormed? 2 46	death?	opsy findings available ompletion of cause of 2 No
on of Vital	ding Physician: Th. th. : After this certificate funeral director, pag	tlon: To Be	25. Was case referexaminer? 1 Pes 2 27. Manner of Dea 1 Natural 2 Accident	No F	lospital: 1 Inpatie 28a. Date of Inju (Month, Da	ry 28b. Time	of 28c. Injury	26. Place of Dea		idence 6		ify)
Division	spital or Attanding ours after death. seral Diractor: After filled in by the fune	Certification:	3 Suicide 4 Homicide	6 Could not be	28e. Place of Inj building, et	ury - At home, farm, c. (Specify)	street, factory, office			(Street and f wn, State)	Number or Ru	al Route Number,
•	To the Hospital or Attandi within 24 hours after death. To tha Funeral Diractor: A completely filled in by the fu	Medical	29a. Certifier (Check only one) 29b. Signature and	25 Medical Exami	sician: To the best ner: On the basis o and manner st	f examination and/or ated.	investigation, in my	time, date and place, opinion, death occur	rred at the time,	date and pl	nd manner as ace, and due signed (Month	to the cause(s)
			Chris 3	dress of person who co	100	eath (Item 23a) (Typ.	pe, Print) KOI/ ST.	SAULS	bung n	ns	1-1	
4	Sta Regist	ate rar	31. Date filed (Mo	NOV 2. 2 20		ar's Signature	4 Soci	Kil.				

State of Maryland / Department of Health and Mental Hygiene 36901 1 - For State Ragistrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Physician Nox CIAINES 0626 15 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner HOSPITAL ERU 15ALTIMORE If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Dec 28, 1929 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** Months Days Hours unk 1 □ M 2 🛛 F 74 216-28-1405 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene. Int: If Item 27 is marked other then "natural", or Items 23e or 28e-1 show 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County ral', or items 23e or 28a-f show Examiner must be notified at TY Yes 2 No MD Director Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2327 N. Charles Street 21218 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ऒ No If Yes, Give Year or Dates: 14 Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: white Specify: þ 3 N Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) unk 16b. Kind of Business/Industry the Medical 15. Decedent's Education unk (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) unk unk 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) unk Be ဂ္ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mercy Medical Center 301 St. Paul Place Baltimore, MD 21202 other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Department of H Important: If ite any injury or ot once. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State '4 □Donation 5 NOther (Specify) in state 21. Signature of Euneral Service Licensee Ronald S. Wade State Anatomy Board Baltimore, MD 21201 Director 655 W. Baltimore Street nan Approximate
Interval Between
Onset and Death Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, for heart failure. List only one cause on each line. Immediate Cause (Final ISCHEMIC BOWEL d475 **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner attending physician and for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 1. Live birth 2 Fetal death in the past 12 months? Month Dav Year 4 Pregnant at time of death 5 ☐ Other (specify) ed by the a detached f 1 ☐ Yes 2 ☐ No 9 ☐ Unknown been signed be should be deta 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has le 2 certificate 280 No 1 ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ပ္ 1 ☐ Yes 2 No 1° Smpatient 2 □ ER/Outpatient 3 □ DOA this 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After 1 Natural 2 Accident Injury 5 Pending hours after death. uneral Director: Aft ely filled in by the fun investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral C 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BALTIMURE, MD 21202 301 PAUL J250711 31. Date filed (Month, Day, Year) NOV 2 2 32. Redistrar's Signature 38-460 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Year Steven Gray November 12, 2004 11:00 AM /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Washington Adventist Hospital Tokoma Park Montgomery If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** 1 M 2 □ F 223-17-1423 Director 55 24, 1949 Virginia Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If Item 27 is marked other then "netural", or Items 23a or 28a-f show any Injury or other treumatic event, the Medical Examinar must be notified as organ. 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2X No Oxon Hill Director Prince George's 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 1143 Southern Avenue #203 20745 USA Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2 ऒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black, White, etc. 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: ģ black 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) laborer home improvements 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Margaret Washington ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Karen Baltimore/friend 1443 Southern Avenue Oxon Hill, MD 20745 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 📉 Other (Specify) in state 22 Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street
Baltimore, MD 21201 21. Signature of Funeral Service Licensee Ronald S. Wade, 1110 hart. Enter the disease, in complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shick, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Unknow Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner van Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): The law requires that the death certificate be executed and Due to (or as a consequence of) the attending physician a shed for use as the burial-Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐ Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown signed by t Part II. Dater significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 Probably 1 ☐ Yes 2 ☐ No Completed 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No ate has b certificate 1 Yes 2 No To the Hospitel or Attending Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other 4 Nursing Home 5 Residence 6 Other (Specify) 2 2 NO 1 🗌 Yes 1 Inpatient 2 P/Outpatient 3□ DOA this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: After Injury 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No within 24 hours after obann.
To the Funerel Director: / 2 Accident 6 Could not be determined 3 🗀 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Dertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier cai (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number NOVEMBER, 12,00 lan s of person who completed cause of death (Item 23a) (Type, Print) Silvers Aue 3-41 31. Date filed (Month, Day, Year) 32. Registrar's Signature State NOV22 Registrar 2004

Physicia		1 - State Registrer 1. Decedent's Name (First, Middle, Last) ALDER ERNESTINE HARDY	Cer	tificate of	Death	2. Date of Dea	19 ^{ay} , 200	4 36903 3. Time of Death 9200
/Medica Examine		4a. Fecility Name (If not institution, give street and number) BLUE POINT NURSING HOME		4b. City, Town, o	BALTIM		4c. County o	Deeth
Funeral Director		5. Social Security Number 277 36 8020 6. Sex 1 M 2 F 7. Age (In yrs. last b) 77 Usual Residence of Decedent	oirthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min		, 1927	9. Birthplace (State or Foreign North Caroli
Maryland e-f ehow	ctor	10a. State 10b. County 10c. City, Tox		MORE				10d. Inside City Limits 1 Yes 2 No
th with the 23s or 28	ai Dire	10e. Street and Number 4103 ROLAND VIEW AVENUE		10f. Zip Code 21	215	1	0g. Citizen of Wh	u.S. OF A.
72 hours after death with the Maryland Instural; or Items 23s or 28s-1 show dical Examiner must be notified at	by Funer	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes, Give Year or Dates:		Vas Decedent of I f Yes, specify Cub I □ Yes 2 No	dispanic Origin? (S an, Mexican, Puer Specify:	Specify Yes or No- to Rican, etc.)		- American Indian, White, etc. BLACK
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Poor I	To Be C	17. Father's Name (First, Middle, Last) RODNEY HUITT (DECEASED)				me (First, Middle, I		EASED)
nd 2 suith ar att au		19a. Informant's Name/Relationship (Type, Print) J.B. HARDY (HUSBAND) 41	b. Mailin 103	g Address <i>(Street</i> ROLAND	and Number or R	ural Route Number VENUE	, city or I own S BALTIMO	RE, MD. 2121!
permit. Pages 1 and Department of Heatt mportent: If item 2 Inty injury or other		1XBurial 2 ☐ Cremation 3 ☐ Removal from State 14 ☐ Donation 5 ☐ Other (Specify)	ZION	sition (Name of natory or other pla V CEMET		Date 24/04 L	20c. Location - C ANSDOWN	ity or Town, State JE , MARYLAND
permit. Pag Department Important: f any injury o once.		21. Signature of Juneral Service Servi	1 1	Name and Addre	ss of Facility • GWYNN K HEIGH	FUNERA	L HOME	21215-6393 TO.,MD.
*		23a. Part1. Enter the disease, or complications that caused the death. Do shock, or heart failure. List only one cause on each line.	not onto		V LIDIOII	TO WARTA		
Physician /Medical Examiner			we	er the mode of dyir	ng, such as cardia	Pan Cr	est,	Approximate Interval Between Onset and Death
/Medical Examiner sicien and e parial-transit	lical Examiner	Immediate Cause (Final disease or condition a. Adenocal resulting in death)	## C (er the mode of dyir	g, such as cardia	c or respiratory arri	est,	Approximate Interval Between
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	1 - For State Registrar	State of Maryland	Certificate of	Health and If Death	Mental Hygier	'	36904
Physician /Medical Examiner	Decedent's Name (First, Middle, Last) ARL 4a. Facility Name (If not institution, give state)	EVGENE reet and number)	HNES 4b. City, Town	n, or Location of Dec	11 /-	Day Year 5 2607 4c. County of Death	3. Time of Death
Funeral Director	5. Social Security Number (6. Sex 1 1	RE HCSpil 7. Age (Intyrs. last	A R C S t birthday) If Under 1 Yes Months Day				1 t iL E place (State or Foreign PRYLAND
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6 uter death with the Mar r tteme 23a or 28a-f e planer must be mutilliad planer all Director	10e. Street and Number 114 SHp FRA	ME ROAO 2. Was Decedent Ever in U.S.	10f. Zip Code	2122	0	Citizen of What Cour	A.
215-0036 thin 72 hours after de. An "naturel", or iten Madral Examinar Apleted by Fun	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces 1 Yes 2 No If Yes, Give Year or Dates:	13. Was Decedent of If Yes, specify Co	lo Specify:	no Rican, etc.)	14. Race - Americ Black, White, Specify:	
d 21215-0(d 21215-0(filed within 72 hou Hygiene. ther then "natura ent, the Medical E e Completed	15. Decedent's Educi (Specify only highest grade Elementary/Secondary (0-12)		6a. Decedent's Usual Occ (Give kind of work don life. DO NOT use ret	e during most of w	orking 16b.	Kind of Business/Ind	dustry /
aryland should be file nd Mental Hy marked oth amatic event To Be C	17. Father's Name (First, Middle, Last) LARRY F. 19a. Informant's N. e/Relationship (Type)	HINES II			Me (First, Middle, Maide Ne WE	HOUT	
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Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iteme 23a or 28a-1 ehow any injury or other traumatic event, the Madical Examiner man be notified at once. To Be Completed by Funeral Director	1 ☐ Burial 2 ☐ Cremation 3 ☐ Rei 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee	GREC	NUOTH (10) 22. Name and Add	MATIORY //	20.04 B	AT MUKE,	MARY CANE
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To the Hospital or A within 24 hours after To the Funeral Direct Completely filled in by Medical Certif	29a. Certifier (Check only one) 1 Certifying Physic 2 Medical Examiner 29b. Signature and title of certifier	ian: To the best of my knowled : On the basis of examination a and manner stated.	and/or investigation, in my	opinion, death occu	rred at the time, date an	d place, and due to t	he cause(s)
4/	30. Name and dress of person who omp	Ellos An		12821	29d. Da	Ite signed (Month, D.	ay, Year)
/ 1	DR Melinda Ellic 31. Date filed (Month Day Year)	The same of the sa	ANKlin Se	WARE D	O. BAITim	CRE Md	21237

Dennis Edward Hayden 04-0 MAN

		1 - State Registrar 1. Decedent's Name (First, Mi	iddle (ast)			Certificate of	Death	2. Date of Deat	ng. No	04	3690												
Physic		Dennis Edwar		den				Month Octobe	Day	Year 200	04 0113												
/Medi Exami		4a. Facility Name (If not institu	ition, give st	reet and numbe	ar)	4b. City, Town, o	or Location of Death		4c. Count														
		7606 Seven I	Mile	Lane 2	2nd Floo		esville			time	ore												
uneral Director		5. Social Security Number 072-40-8522		M 2□F	Age (In yrs. last bii 56	rthday) If Under 1 Year Months Days		8. Date of Birth (Month, Day, Aug 19,	^{Year)} 48	9. Bird Co Net	hplace (State or Fore nuntry) W York												
*		Usual Residence of Decedent 10a, State 10b, Cou			10c. City, Tow	n or Location					10d. Inside City Lim												
f sho	ō	MD Ba	ltimor	re	Pi	kesville					1 ☐ Yes 21 1												
a or 28a-	I Director	10e. Street and Number 7606 Seven	Mile I	Lane 2nd	l flr	10f, Zip Code	21208	10	0g. Citizen of	What Co USA	untry?												
jiene. r than "natural", or Items 23a or 28a-f show the Madical Examination wat be notified at	by Funeral	11. Marital Status 1 Never Married 2 Never Married 2 Never Married 2	Married	2. Was Deceder Armed Force 1 X Yes 2 [If Yes, Give Year or Date:	s? ⊒No	13. Was Decedent of If Yes, specify Cub		pecify Yes or No- o Rican, etc.)		ck, White	ncan Indian, e, etc. hite												
"natural",		15. Dece (Specify only hig	dent's Educa	ation		Decedent's Usual Occup	pation during most of wor	kina	16b. Kind of E	Business/	Industry												
Hygiene. other than "r ant, the Mar	Completed	Elementary/Secondary (0-1	2)	College (1-40	or 5+)	(Give kind of work done life. DO NOT use retire police off	icer		law en		ement												
d other	Be	17. Father's Name (First, Mide						ne (First, Middle, M		me)													
arka atic	2	John Hayden		- Drinel	406	Mailin Adulus / Charles		ie Molbe		Ot-1- 7	T- 0- 4-1												
E 00 E		19a. Informant's Name/Relati				o. Mailing Address <i>(Street</i> 32 Anneslie					up Code)												
item 27 i		20a. Method of Disposition	DIOCIIC	<u> </u>		f Disposition (Name of	. Road Dal		20c. Location	212 • City or	Town, State												
vaician		23a. Part. Enter the disease shock or heart failure.	yce Licenser I S W W o, or complic List only one	ations that caus	sed the death. Do	State Anat Baltimore,				lore	Approximate Interval Between												
ledical aminer		23a. Part. Enter the disease shock or heart failure. Immediate Cabse (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	o, or complic	Due to (or	as a consequence	not enter the mode of dyi where Car of):				ac	Approximate												
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gned by the attending physician and included for use as the burial transit	by Physician/Medical Examiner	23a. Part. Enter the disease shock or heart failure. Immediate Cabse (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	b. c. d.	Due to (or : Du	as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence as a consequence	of): a Georgi	ing, such as cardiac	or respiratory arre	23d. Da Mo	ate of deli	Approximate Interval Between Onset and Death												
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itter death. Director: After this certificate has been signed by the attending physician and inposition and inposition and inposition and inposition are set the furneral director, page 2 should be detached for use as the burial-transit on one of the furneral director.	Certification; To Be Completed by Physician/Medical Examiner	23a. Pant. Enter the disease shock or heart failure. Immediate Cabse (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	ditions continued and and and and and and and and and an	Due to (or Due to (or	as a consequence as a c	of): of):	ven in Part I. 26. Place of Deather: 4 □ Nursing Hind At 19th	23e. Did tob 1 Tye 24a. Was an autops: perform Yes 2 th (Check only one ome 5 Reside 28d. Describe ho 28f. Location (Stir	23d. Da Mo Dacco use con Mo No No No No No No No No No No No No No	ate of delificanth delificanth are recorded to the control of the	Approximate Interval Between Onset and Death & Conset	ther death. Director: After this certificate has been signed by the attending physician and inpolarized the funeral director, page 2 should be detached for use as the burial-transit of polarized the funeral director.	Certification; To Be Completed by Physician/Medical Examiner	23a. Part. Enter the disease shock or heart failure. Immediate Cabse (Final disease or condition resulting in death) Sequentially list conditions, if any, teading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 — Yes 2 — No 9 — Unknown Part II. Other significant con yellow the past 12 months? 1 — Yes 2 — No 9 — Unknown 25. Was case referred to medexaminer? 1 — Yes 2 — No 27. Manner of Death 1 — Natural 5 — Period of the past 1 — Period of the	ditions continued and inding estigation uld not be termined	Due to (or Due to (or	as a consequence as a c	of): of): of): of): of): utpatient 3 DOA Other (specify) _ 28c. Injury Months of Injur	ven in Part I. 26. Place of Deather: 4 Nursing Hard at Nursing Hard and place	23e. Did tob 1	23d. Da Mo Dacco use con s A No no 24b. no 24b. no s occurs of the second of the secon	ate of delificanth atribute lo 3 Pro Were au prior to co death? 12 Yes mer (Spectred	Approximate Interval Between Onset and Death Conset and Death Conset and Death Conset and Death Populary Pay 1 the cause of death? Obably 4 Unknown topsy findings availate completion of cause of Death Populary Pay 1 S.C. Conset and Populary Pay 1 S
n. After this certificate has been signed by the attending phys funeral director, page 2 should be detached for use as the	To Be Completed by Physician/Medical Examiner	23a. Part. Enter the disease shock or heart failure. Immediate Cabse (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	ditions continued and a distance of the continued and a distan	Due to (or Due to (or	as a consequence as a c	of): of):	ven in Part I. 26. Place of Deather: 4 Nursing Hard at Nursing Hard and place	23e. Did tob 1 Tye 24a. Was are autops: perform Yes 2 th (Check only one ome 5 Reside 28d. Describe ho 28f. Location (Str. City or Town) , and due to the carried at the time, da	23d. Da Mo Dacco use con s A No no 24b. no 24b. no s occurs of the second of the secon	ate of delification the tribute to 3 Professional Profession and the tribute to death? Were au prior to death? The red	Approximate Interval Between Onset and Death Conset and D												

DHMH 17 Rev 1/2001

Registrar

32. Registrar's Signature

NOV 2 2 2004

		1. Decedent's Name (First, Middle, Last)			rtificate of		2. Date of Dea			36906 3. Time of Death
Physicia	ın	Hildred Heindel	Hare				Month Nov.	18 2	Year OO4	10:00 p M
/Medic Examin		4a. Facility Name (If not institution, give s	treet and number)		4b. City, Town,	or Location of Death	1	4c. County	of Death	
- Aut	300	4000 Maple Grove	Rd.		Hamps	stead			arrol	1
uneral rector		5. Social Security Number 6. Sex 198–10–7639		yrs. last birthday) 5 Yrs.	If Under 1 Year Months Days		8. Date of Birth Month, Day March	8,1919	9. Birthp Cour Penr	place (State or Foreign Tity) Isylvania
M III		Usual Residence of Decedent 10a. State 10b. County	100	c. City, Town or Lo	ocation				1	10d. Inside City Limits
a-f sh ilified	ctor	Maryland Carroll		Hampste	ead					1 ☐ Yes 2 🗹 No
or 28	Funeral Director	10e. Street and Number	Da		10f. Zip Code	1074		10g. Citizen of \	What Cour	ntry?
nust	erai	4000 Maple Grove	RO.	in U.S. 13			pecify Yes or No-			can Indian,
if item 27 is marked other than "natural", or items 23s or 28a-f show or other traumatic event, the Medical Examiner must be inclifted at	by Fun	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	Amed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:		If Yes, specify Cu 1 ☐ Yes 2 🖾 No	Hispanic Origin? (S ban, Mexican, Puert o Specify:	o Rican, etc.)		ck, White, V: Whi	etc.
stural cal Ex	ted b	15. Decedent's Educ	cation	16a. Dece	dent's Usual Occu	upation	dia -	16b. Kind of B		
Me In	Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)			e during most of wor ed)	rking	63. 1.		ADMIN I
it.		7		Sear	nstress	19 Mathoda Nas	ne (First, Middle,			Factory
ed of	ä	17. Father's Name (First, Middle, Last) John Henry Heinde	יו				a Violet		10)	
mark	2	19a. Informant's Name/Relationship (Type		19b. Maili	ng Address (Stree	et and Number or Ru			State, Zip	Code)
27 is r trau		Gregory K. Hare -		708 8	Sullivan	Rd. West	minster,	Md. 21	157	
item othe		20a. Method of Disposition	20		osition (Name of matory or other pl		Date	20c. Location -		own, State
int: if		1 ☐ furial 2 ☐ Cremation 3 ☐ Ro `4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	Lineboro	Cemeter	y Nov. 22	, 2004	Linebo	ro, M	ſd.
important: if item 27 is any injury or other trau once.		21. Signature of Funeral Service License	99	E	2. Name and Add ckhardt]	ress of Facility Funeral Cl nil Dr. Ma	napel P.	A.	21102)
6 N.		23a. Part1. Enter the disease, or complishock, or heart failure. List only on	cations that caused the	death. Do not en	ter the mode of dy	ring, such as cardiac	or respiratory ar	rest,	21102	Approximate Interval Between
sician		Immediate Cause (Final disease or condition	End St			Disea			- 1	Onset and Death
edical miner		resulting in death)	Due to (or as a co							MATERIAL CONTRACTOR
ilitiei	_	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a co	nsequence of):					-	
usit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	240 (0. 20 2 0.							
ysician and ne burial-transit	Еха	resulting in death) Last	Due to (or as a co	nsequence of):						
hysicia the bur	licai		l							
attending physical for use as the t	/Mec	IF FEMALE: 2	3c. If yes, outcome of pr	regnancy				23d Da	te of delive	90/
for us	cian	in the past 12 months?	1 Live birth 2 ☐ 4 Pregnant at time	Fetal death 3	Ectopic pregnan Other (specify)	су			nth	Day Year
achec	Physician/Medi	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	9☐ Unknown							
signed by the atte d be detached for	by Pl	Part II. Other significant conditions con	tributing to death but no	ot resulting in the o	underlying cause g	iven in Part I.		_/		he cause of death?
been sig should b	ted	Dementia					101			pably 4 □Unknown
V2 01	Completed						24a. Was autop	sy	Were auto prior to co death?	ppsy findings available impletion of cause of
certificate ha	Con							2☑No	1 Yes	21 No
rector	Be	25. Was case referred to medical examiner?	lospital:	۵۵۶۵۵	- 2525	th or	ath (Check only o		0. (0.	6.1
this ald	. To	1 ☐ Yes 2 ☐ No	28a. Date of Injury	2 ER/Outpatie	of 28c. Inj	ury at	lome 5 Resid	dence 6 00th now injury occur		y)
r: Atter e funer	atior	1 ☑ Natural 5 ☐ Pending investigation	(Month, Day Ye	ar) Injury		ork? ⊒Yes 2⊒No				
in by the	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - building, etc. (S	At home, farm, st pecify)	reet, factory, office	9	28f. Location (S City or Tox		er or Rura	al Route Number,
To the Funeral Director: completely tilled in by the	Medical Co	(Check only 2 Medical Examin	sician: To the best of my ner: On the basis of exa and manner stated.	y knowledge, dea imination and/or in	th occurred at the ovestigation, in my	time, date and place opinion, death occu	e, and due to the curred at the time,	cause(s) and maddate and place,	anner as s and due te	stated. o the cause(s)
9 9	Med	29b. Signature and title of certifier	and manner stated.		29c. Lice	nse number		29d. Date signe	d (Month,	Day, Year)
t E	1	/	44.0		221	S 7 11				
To the		M. Nasir	MD		102	5711		11 /21/	300	4

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registre Certificate of Death Reg. No. 2. Date of Death 1 Decedent's Name (First Middle, Last) Month Vear **Physician** Evelvn Adele Horn 2004 November 18 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Chapel Hill Nursing Center Randallstown Baltimore 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex **Funeral** Days Hours Min 1 □ M 2 🔽 F 218-22-6974 76 Feb 9 1928 Md Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d, Inside City Limits 10a. State 10b. County Pages 1 and 2 should be filed within 72 hours after death with the Marylan ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or Items 23a or 28e-1 show ury or other traumetic event, the Markel Examinational Learn Miled at Md Carroll Sykesville 1 X Yes 2 No **Funeral Director** 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 7426 Village Road Apt 216 21784 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11, Marital Status 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: white þ 3 XWidowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) homemaker domestic 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Charles Worth Oursler Caroline Adele Baker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7223 Caracara Ct., Sykesville, Md 21784 Kim A. Novak (daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) permit. Page:
Department of
Importent: If i
eny injury or
once. Garrison Forest Vet. 11-24-04 Owings Mills, Md 22. Name and Address of Facility Haight Funeral Home & Chapel 21. Signature of Funeral Service Licensee tredigt tropiotismit P.O. Box 195 Sykesville, Md 21784 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** VQ disease or condition resulting in death) /Medical Due to (or as a conseque Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 ☐ Fetal death 3 DEctopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) signed by the at d be detached fo 1 ☐ Yes 2 🗷 No the 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No has 1 Yes 2 X No or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient ij 2 1 ☐ Yes 2 🟋 No 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Certification: After 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No death. Director: 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) within 24 hours after To the Funeral Dire 4 Homicide Hospital 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) cal (Check only one and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier Da5112 11/20/2004 mpleted cause of death (Item 23a) (Type, Print) NDa1117 30. Name and address of person who co Suite 101 , crossroods 20 Kausa lahoora 31. Date tiled (Month, Day, Year) NOV 2 2 2004 32. Registrar's Signature State Registrar

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			For 1 _ State	State of Mar	yland		nt of Health and			
			1 - State Registrar			Certifica	te of Death		eg. N2 () ()	36908
П	Physici	n	1. Decedent's Name (First, Middle, Las	" C 11		1		2. Date of Dea	Day Year	W. Nine of Death
П	/Medic		Nobert	<u>C.</u> H	0C	kman		NOV	18 000	4 2.501.
	Examin	er	4a. Facility Name (If not institution, give	street and number)		4b. City	, Town, or Location of De		4c. County of Dea	th
			1009 Evan	5 War	1.		SALTIMOR			
	Funeral		5. Social Security Number 6. S	7. Age (ZIM 2□F	In yrs. la	st birthday) If Under Months	er 1 Year If Under 24 H Days Hours M	in. (Month, Day	Year) 9. Bir	thplace (State or Foreign
	Director		Usual Residence of Decedent		- 1	8 113.		9-4-	26 1111	HCYLHAUS
	and		10a. State 10b. County	1	10c. City,	Town or Location				10d. Inside City Limits
	Mary f sho	ō	MN RATI	MORE		P.M.	TMARE			1 ☐ Yes 2 No
	the 28e-	Director	10e. Street and Number	MORO			n moles	1	0g. Citizen of What C	puntry?
	be filed within 72 hours after death with the Maryland ital Hygiene. Adother then "neturel; or Items 23e or 28e-f show event, the Medical Examiner must be notified at event.			sina Do	7		21234		()5A	
	leath	Funeral	10103 Font	12. Was Decedent Ev	er in U.S	. 13. Was Dec	edent of Hispanic Origin?	(Specify Yes or No-	14. Race - Am	erican Indian,
	fter of the rest o	Fun	1 Never Married 2 Married	Armed Forces? 1 May Yes 2 □ No		If Yes, sp	edent of Hispanic Origin? ecify Cuban, Mexican, Pu	erto Rican, etc.)	Black, Whi	te, etc.
ž	urs a	by	3 Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes	2 No Specify:		Specify: U	inite.
215-0036	2 ho	Completed	15. Decedent's Ed	ucation		16a. Decedent's Us	ual Occupation	undring.	16b. Kind of Business	/Industry
Š	hin 7 9n "r Med	ple	(Specify only highest gra	College (1-4or 5+)		life. DO NOT	rork done during most of v use retired)	VOIKING	0 .	
7	filed within 72 Hygiene. other then "ne(ent, the Medic	Con	8			sales			tood.	
g	be file	Be (17. Father's Name (First, Middle, Last)	· ·			18. Mother's N	lame (First, Middle, I	Maiden Surname)	
<u>=</u>		Tol	Albert H	ockman			Ma	ruh.	Denn	15.
Maryland	2 should and Men is marke eumatic		19a. Informant's Name/Relationship (7	ype, Print)		19b. Mailing Addres	ss (Street and Number or	Rural Route Number	, City or Town, State,	Zip Code)
_	127 je d		JAMES HOCKE	1an-Sor		1825	Taica reei	and b	ALTIMORE	MD 21222
<u> </u>	es 1 a of Hea fitem rothe		20a. Method of Disposition 1	Demoval from State	20b. Pla	ice of Disposition (Nametery, crematory or	ame of other place)	Date	20c. Location - City or	Town, State
Ĕ	Pages nent of ent: If it ury or o		'4 Donation 5 Other (Specify		Mec	rdowrich	e Monitark 1	1-22-04	Jkridge	MD.
Baltimore,	permit. Pages Depirtment of I Importent: If it any njury or o		21. Signature of Funeral Service Licen	590		22. Name	nd Address of Facility	ALTIMOR	E. MDZ	12311
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	dea of to	sicla	in the past 12 months? 1 \(\subseteq \text{Yes} 2 \subseteq \text{No} \)	4☐Pregnant at tir 9☐Unknown					Month	Day Year
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וס ר	ng Phy ter this		27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day Y		28b. Time of Injury	28c. Injury at Work?		w injury occurred	home.
<u> </u>	Attending For death. Sector: After by the funeral	atle	2 Accident investigation			М	1 ☐ Yes 2 ☐ No			
DIVISION	r Att	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury building, etc.	- At hom (Specify)	ne, farm, street, facto	ry, office	28f. Location (St. City or Town	reet and Number or R. s, State)	ural Route Number,
	itel o rs aft rel Di	Cer								
	e Hospitel or At 24 hours after o e Funerel Direc etely filled in by	cal	29a. Certifier (Check only 2 Medical Exam	ysician: To the best of a	my know	ledge, death occurre	d at the time, date and pla in, in my opinion, death of	ice, and due to the ca	use(s) and manner as	s stated.
	To the Hospitel or Attent within 24 hours after death To the Funerel Director: completely filled in by the	Medical	one)	and manner state	d.					
	To To To	~	29b. Signature and time of certifier	1+11	h		oc. License number		9d. Date signed (Mont	
	1/		- Clen Cul	reupent	IVE		124356		November.	19, 262 4
	10,		30. Name and address of person who	111/4 0	- /	23a) (Type, Print)	0 0, 910	3 Frank	in Square !	h.
	1		31 Date filed (Month Day Your	-	mkl		Come Ctr	But . The	1 12123	/
	Sta Registr		NOV 2 2 20	32. Registrar's	s signatu	6 1	na Kal			
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Bridget A. Heptinstall Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Unpend Item 25 April 10 1 Item 25 April 10 1 Item 25 April 10 1 Item 25 April 10 Item 25 Ap AKG Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2, Date of Death Month **Physician** BRIDGET HEPTINSTALL ANN November 18, 2004 4:39 A M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Towson Baltimore Greater Baltimore Medical Center 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 □ M 2 54 218-62-3963 Director August 18,1950 England Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits the Medical Examiner must be notified at 1 ☐ Yes ¾ No Directo Maryland Baltimore Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 6 6632 Walnutwood Circle 21212 USA 238 death 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes XXNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural; or Item any Injury or other traumatic event, the Mudical Examine 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White þ 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Catering Hospital 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Ann Enraght Porter Robert Hodgson Heptinstall 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert H Heptinstall Father 6632 Walnutwood Corcle Baltimore, Maryland 21212 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Greenmount Cemetery 11/19/04 Baltimore, Maryland ¹ 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home Inc 21. Signature of Funeral Service Licensee 6500 York Road Baltimore, Maryland 21212 WILL C Approximate Interval Between Onset and Death Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Pnysician Arteriosclerotic cardiovascular disease /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner attending physician and for use as the burial-transit be executed Due to (or as a consequence of): Records, P.O. Box 68760 Physician/Medical the death certificate IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetel dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetel death 3 Ectopic pregnancy ed by the atter in the past 12 months? Month Dav 5 Other (specify) 4 Pregnant at time of death 1 ☐ Yes 2 X No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 4 Unknown Diabetes mellitus 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? 2□ No 2 No es. Yes of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 XYes 2 No 1 Inpatient 2XXR/Outpatient 3 DOA Certification: To 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28h Time of To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After the completely filled in by the funeral 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be determined 3 🗀 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Momicide ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d, Date signed (Month, Day, Year) 29b. Signature and itle of certifier O.C.M.E. November 18, 2004 104 address of person who completed cause of death (Item 23a) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201 32. Registrar's Signature

DHMH 17 Rev 1/2001

State

Registrar

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			1 - For State Registrar	State of M	/laryland	l / Depa	artmen tificat	t of H	ealth a Death	and M	lental Hy	giene (004	36910
	Physici	an	Decedent's Name (First, Middle, La Ma	^{ist)} rgaret Kat	therine	e Hall					2. Date of De Month	nber 10	Yeer S 2004	3. Time of Death 1:50 P M
	/Media		4a. Facility Name (If not institution, give					Town, or	Location of	of Death	NOVE		unty of Death	
4	Examir	ıer	Manor Care Ross		,		,	ossv:				Ва	ltimore	e Co.
	Funeral		5. Social Security Number 6.5	Sex 7. A	Age (In yrs. la	st birthday)	If Under	r 1 Year	If Under Hours	24 Hrs. Min.	8. Date of Big (Month, Da	th v Year)	9. Birthp	place (State or Foreign
	Director		215-05-3102	1 □ M 2KCXF	88	Yrs.	Months	Days	Hours	MID.	Aug.	15,191	5 Mary	land
	٦٥		Usual Residence of Decedent		10a City	Town as Lo	antina						-	0d. Inside City Limits
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Iteme 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must be notified at Ance.	Funeral Director	10a. State 10b. County Maryland Bal	timore	Toc. City,	Town or Lo	cation			Hale	thorpe			1 ☐ Yes 2X No
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	r dez	nue	11. Marital Status	12. Was Deceder Armed Forces	s?	. 13.	Was Dece f Yes, spe	dent of Hi cify Cuba	spanic Ori n, Mexicar	gin? (Spe n, Puerto	ecify Yes or No Rican, etc.)	- 14.	Race - Americ Black, White,	
36	or I	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2√√ If Yes, Give Year or Dates			1 🗆 Yes	a∏ No	Specify:			Spe	ecify:	
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	nd 2 alth a 27 Is r trau		Michelle Benton	/ Daught	er	171	5 Rit	tenh	ouse	Ave.	Balt	imore,	MD 2	1227
ē,	s 1 a f Hea item othe	-	20a. Method of Disposition		CAL	ice of Dispo	sition (Na	me of other plac	e)		ate	20c. Locati	on - City or To	own, State
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Funeral		Suburban Hosp	_	7. Age (In yrs. 96	last birthday) Yrs.	If Under 1 Months	Year If	hesda Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da	th ly, Year)	ntgom 9. Birthp Cour	ery place (State or Foreig otry (Unknown)
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Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mental Hygiene. Importent: If item 27 is marked other than "netural", or items 23a or 28a-1 show any injury or other traumatic event. The Medical Examinat must be multiled at once.	by Funeral	11. Marital Status 1 □ Never Married 2 □ Marrie 3 ☒ Widowed 4 □ Divorced	Armed Fo	2□No (Ur ve	1k.)	Was Decede f Yes, specif 1 ☐ Yes 2		anic Origin? (Sp Mexican, Puerto Specify:	ecify Yes or No Rican, etc.)	14. Ra Bla Speci	ice - Americ ack, White, ify:	
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Sion tending leath. tor: Afte	Certification: To Be	examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investiga 3 Suicide 6 Could no	28a. Date (Mon	of Injury th, Day Year)	28b. Time of Injury	28 M	C. Injury at Work?	5. Place of Deat 4 Nursing Ho 5 2 No	ome 5 Residente l	dence 6 Ot how injury occu	rred	y) - If Route Number,
Hospital or 4 hours afte Funeral Dire	ical Certif	(Check only 2 Medical E:	Physician: To the kaminer: On the b	asis of examina	owiedge, death	occurred a	t the time,		City or Tox	vn, State) cause(s) and m	ianner as st	ated.
To the I within 2 To the I complet	Medical	29b. Signature and title of certifier	and man	ner stated.	w		License nu			29d. Date signi		
60	1	30. Name and address of person w	On Hon	10th	MA	Print) 9 9 0	1 M	edical	Cente	Prive	R	9,2004
St. Regist	ate trar	31. Date filed (Month, Day, Year)	2004 32. F	Registrar's Sign	ature	Sy	out.				,	

DHMH 17 Rev 1/2001

7:56 PM

11-08-04

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** November 16, 2004 5:45 PM Virgilio Hassang /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Washington Adventist Hospital Takoma Park Montgomery 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Dec. 31,1928 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** 1√ M 2□ F 127-36-3527 75 Panama Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County is marked other than "natural", or items 23a or 28a-f show sumatic event, the Medical Examiner musice notified at 1 ☐ Yes 2 ☐ No Be Completed by Funeral Director Maryland Prince George's College Park 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 4709 Lackawanna St. 20740 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 TYes 2 No Specify: Panamanian Asian 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Heating & Air Condition Technician permit. Pages 1 and 2 should be filed Department of Health and Mental Hygi Importent: If item 27 is marked other any injury or other treumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Hassang Eloisa Ceballos Samuel 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Yamiret Castaneda / Daughter 3210 Wisconsin Ave., NW #101; Washington DC 20016 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Nov.19,2004 Gate of Heaven Cem. Silver Spring, MD `4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fuperal Service Licensee

Rapp Funeral & Cremation Services
933 Gist Ave., Silver Spring, MD

23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Rapp Funeral & Cremation Services 20910 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** a END-STAGE ISCHEMIC CARDIOMYOPATHY /Medical Due to (or as a consequence of) Examiner SEPSIS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner Hospitel or Attending Physicien: The law requires that the death certificate be executed signed by the attending physicien and d be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical IF FEMALE If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 MUnknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed this certificate 1 ☐ Yes 2 ☐ No 2 × No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Minpatient 2 ER/Outpatient 3 DOA Medical Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death After 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation To the Funeral Director: 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide Location (Street and Number or Rural Route Number City or Town, State) 4 Homicide within 24 hours a To the Funerel I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D-17874 11-16-04 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

S. M. NAYAR, MD, 3717-38" ME COTTAGE CITY, MD 20722 32. Registar's Signature Day, Year) 31. Date filed (Month, Registrar

		1 - For State Registrar	State of M	aryland /		ment of iicate of		and Me	ntal Hy	giene	7111	4	3691
Physi -/Med	lical	Decedent's Name (First, Middle, La: Virginia Ahlstr An Facility Name (If not institution, giv.)	om Hani		41	o. City, Town,	or Location o	1	Date of De Month Novemb	er I	5, 20		3. Time of Death 8:45 P
Funera	1	Sunrise Assisted 5. Social Security Number 6. S	Living C		pirthday) If		ckvill	e 24 Hrs. 8.	Date of Bir (Month, Da	th ay, Year)	Mont	gome	ery ace (State or Foreig ry) York
Directo works I		085-22-7436 Usual Residence of Decedent 10a. State		10c. City, To		_	omac	Į) i	an. 23), 13	721		d. Inside City Limit
with the I	Funeral Director	10e. Street and Number 9205 Winterset	Dr.	1		10f. Zip Code	20854				zen of Wha		
ING 21213-UU36 be filed within 72 hours after death with the Maryland tal Hygiene. d other then "naturel; or tems 23a or 28e-f show event; the Medical Eval, her must be retified at	by Funera	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 🏋 Divorced	12. Was Decedent Armed Forces? 1 ☐ Yes 2 🔀 If Yes, Give Year or Dates:	•		Decedent of s, specify Cul		gin? (Specif , Puerto Ric	y Yes or No can, etc.))-	14. Race - Black, Specify:	White, et	
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	To Be C	17. Father's Name (First, Middle, Last) Rudolph Axe	21	Ahlstro	om		18. Mothe He	rs Name <i>(F</i> 1en		tura	ı .		ston
		19a. Informant's Name/Relationship (George A. Hani /	• • • • • • • • • • • • • • • • • • • •	5	600 M	ddress (Stree	Dr., B	ethes	da, MI	20	814		
Baltimore, permit. Pages 1 ar Department of Hea Importent: if item: eny injury or other		20a. Method of Disposition 1 Burial 2 Cremation 3 1 Donation 5 Other (Specification)		20b. Place cemet Chesa	apeake	on (Name of bry or other pla Crema	tory	Nov.	17 ,	F	cation - Cit Beltsv	7 i 110	e, MD
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	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ Inpatie	ent 2 ER/C	Outpatient :	B DOA O	26. Place her: 4X Nu		Check only of		Other (Specify)	
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pitel or ours afte		4 Homicide determined	28e. Place of Inj	c. (Specify)					City or Tov	vn, State))		Route Number,
To the Hos within 24 ho To the Fun completely f	edical	(Check only 2 Medical Examone)	niner: On the basis o and manner st	f examination a		igation, in my	opinion, deat		at the time,	date and	place, and	due to ti	he cause(s)
Tot with	2	29b. Signature and title of certifier		MD			se number 33474				e signed (A ovmeb		ay, Year) 7, 2004
N		30. Name and address of person who David Hansen M.D					7; Was	hingt	on DC	200	016		
S Regis	tate trar	31. Date filed (Month, Day, Year)		ar's Signature	4								

State of Maryland / Department of Health and Mental Hygie 2004

Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Nov. 12, Day 2004 **Physician** 6:53 pM Haney /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Prince Georges Mitchellville 10450 Lottsford Road 8. Date of Birth
(Month, Day, Year)
(Month, Day, Year)
(Month, Day, 1914)
Pennsylvania If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 90 Yrs. 5. Social Security Number Birthplace (State or Foreign
Country) **Funeral** Months Days Hours 1 M 2 XF 176-07-5845 Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. Count 7 is marked other then "naturel", or Items 23e or 28a-f ehow treumatic event, the Maxical Examination was be notified at 1XXes 2 □ No Prince Georges Mitchellville Directo 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 10450 Lottsford Road 20721 United States Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give A Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. filed withIn 72 hours after Hyglene. 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: white þ 3 X Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education permit. Peges 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "na any injury or other treumatic event, II a Marie 2008. (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) housewife homemaker 12 17. Father's Name (First, Middle, Last) 18 Mother's Name (First Middle Maiden Sumame) Chloe Lansberry Shirey Clvde 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12317 Arrow Park Drive, Fort Washington, MD 20744 Ronald Haney, Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 11 Burial 2 □ Cremation 3 □ Removal from State
'4 □ Donation 5 □ Other (Specify) 11/17/04 Clearfield, PA Bradford Cemetery 22. Name and Address of Facility
Rapp Funeral and Cremation Services 21. Sign sure of Funeral Service Censes 933 Gist Avenue, Silver Spring MD 20910 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Priysician Emphysema disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Anemia Sequentially list conditions Due to for as a constituence of Examiner cause. Enter Underlying Cause (Disease or injury that initiated events the attending physician and hed for use as the burial-transit requires that the death certificate be executed Renal Mass resulting in death) Last Due to (or as a consequence of) Records, P.O. Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1☐Live birth 2☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Year Day 4☐ Pregnant at time of death 5 Other (specify) 9 Unknown been signed by should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 XUnknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital Hospital or Attending Physician: 24 hours after death. Funerel Director: After this certifice 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) examiner Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) (Specify) Hospital: 1 ☐ Yes 2 😾 No 1 Inpatient 2 ER/Outpatient 3 DOA Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) To the I within 2. 29d. Date signed (Month, Day, Year) 29b Signature and title of certifie 29c. License number 11/15/09 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4000 Mitchellville Road, Bowie, MD William Dubois 31. Date filed (Month, Day, Year) 32. Registrar's Signature Registrar DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

			State of Maryland / Department of Health and Mental Hygiene 1- For State Registrar Certificate of Death Reg. N2 004 369	16
	60		1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of	Death
	Physici /Medic		Dr. Joseph Howard Inloes 102	2 AM
	Examin		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death County of Death County of Death County of Death County of Death County of Death	
	Funeral		5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 2 Hrs. 8. Date of Birth 9. Birthplace (State of Months, Days Hours Min.) (Months, Days Hours Min.)	r Foreign
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	ryland how		10a. State 10b. County 10c. City, Town or Location 10d. Inside Ci	•
	Ba-fs	Director	MD Wicomico Salisbury 1897es	2 No
	with th		10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 229 Florida Ave. 21801 United States	
	ns 234	Funeral	11. Marriel Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-	
36	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 Ie marked other than "natural", or Items 23a or 28a-f show other treumatic event, the Modical Examinar must be multied at	by Fun	Armed Forces? 1 Never Married 2 Married 1 Married 2 Married 1 Married 2 No Specify: 1 Never Married 2 No Married 2 No Married 2 No Married 1 No Specify: 1 Yes 2 No Specify: Specify: White, etc.	
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ary	2 should be and Mental le marked (reumatic ev	-	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)	
	s 1 and 2 of Health item 27 l		April Smith/daughter 6607 Darnall Road, Towson, MD 21204	
ore	ges 1 it of H if ite or oth		cometery, crematory or other place) 1 \(\text{Surial} \) 2 \(\text{Cremation} \) 3 \(\text{Removal from State} \) \text{Competery, crematory or other place} \) \text{Portion of Torontony of the place} \)	
altimore,	permit. Pages Department of I Important: If ite eny injury or of		The state of the s	T
Ba	Depariment Department		21. Signatur of Funeral Service Licensee 22. Name and Address of Facility Ruck Towson Funeral Home. Stephen Coster 1050 York Road, Towson, MD 21204	, Inc
			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, interval Bah Interval Bah Onset and	ween
B	Pnysician		Immediate Cause (Final disease or condition resulting in death) a. ardiac Grrhuftmia (15 n	
	/Medical Examiner		Due to (or as a consequence of):	
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Vital Records,	e la has je 2	Completed	Charles Paul fall seconds & Naghus 24a. Was an autopsy findings autopsy performed? 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No	available ause of
/ita	ysicien: Th is certificate director, pag	Be (25. Was case referred to medical examiner?	
of/	d is	- To	1 Yes 2 No Hospital: 1 Inpatient 2 DEP/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred	
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_	Hospite 4 hours Funerel	Medical Co	29a. Certifier (Check only one) 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s and manner stated.)
	To the within 2 To the complet	Me	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)	
	1		Dent & / haring 0-20050 11/17/04	
ì	1/2		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	
1	Ų.		31. Date Med (Month, Day Year) 32. Registrate Signature NOV 2 2 2004 A Secretary Signature	218
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year 0:10PM **Physician** Jones Jovember 1/2004 /Medical 4a. Facility Name (If not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death Examiner Hospita Himore If Under 24 Hrs last birthday Date of Birth 5. Social Security Number 6. Sex 9. Birthplace (State or Foreign **Funeral** 1 M 2 F Hours Min. Vory Director be filed within 72 hours after death with the Maryland 10a, State 10b. County City, Town or Location 10d. Inside City Limits r than "natural", or Items 23a or 28e-f show the Medical Examiner must be notified at 1 Nes 2 No Director imore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. College (1-4or 5+) other traumetic event, Be ပ 1 and 2 should Print) (Nueg Informant's Name/Relationship (Type, 19b. Mailing Address (Street and N If Item 27 is Balto MD 21218 Pages 2 Cremation 3 Removal from State permit. Page Department o Important: If any injury or once. Burial ö Jestern (eneter 5 Other (Specify) 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Due (of as a consequence of): **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury to (or as a consequence of): Examiner The law requires that the death certificate be executed oulu month and use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No
9 Unknown 3 Ectopic pregnancy page 2 should be detached for Dav Year 4☐Pregnant at time of death 5 Other (specify) the 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy perform 1 Yes 2 🗌 No or Attending Physician: Be 25. Was case referred to medical examiner? the funeral director 26. Place of Death (Check only one) Hospital: Inpatient Other: 4 Nursing Home 2 ER/Outpatient Certification: To 1 Tes 2**Z** No 3□ DOA 5 Residence 6 ☐Other (Specify) After this Manner of Death 28a. Date of Injury (Month, Day 28d. Describe how injury occurred 1 Natural 2 Accident Injury 5 Pending 2 No 1 Tyes within 24 hours after death. To the Funeral Diractor: A investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[In Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the Medical completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License numbe 29d. Date signed (Month, Day, Year) 29b. Signature and title of certific 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Johns Hyplans N WOITE ST The .Bivehondang 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

NOV 2

2004

State of Maryland / Department of Health and Mental Hygieney For State Registrar Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) Nowember 77, **Physician** 2004 Soe Jung-Lee 11:10 A M /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Ellicott City Howard 3185 Pine Orchard Lane, 202 If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Days | Hours | Min. Aug 22, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 ☐ M 2 € X 216-69-2716 47 Yrs. Korea Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Imperatin: If them 27 is marked other than "nature!" 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits Ellicott City 1 ☐ Yes 2XXNo Maryland Howard Director 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 3185 Pine Orchard Lane, 202 21042 Korean Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 Yes 2/XNo
If Yes, Give
Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: Specify: Korean δ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Store Owner Auto Glass 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Agatha Kang Tae Hyun Lee 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) June Shick Jung/husband 3185 Pine Orchard Lane, 202,Ellocitt City, MD 21042 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Kurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Crestlawn Memorial Gardens Nov. 19,2004 Marriottsville, MD 21. Signature of Funeral Service Licensee Witzke Funeral Homes, Inc. of Columbia lidino 0 5555 Twin Knolls RD, Columbia, 21045 MD 23a, Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on and line. Approximate Interval Between Inset and Dean Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical the use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? ρ Month Day Year 4☐Pregnant at time of death 5 Other (specify) the 9 Unknown ģ signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 227 No 24a. Was an autopsy performed Yes 2 certificate 1∐ Yes or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 5 X Residence 6 □ Other (Specify) Certification: To this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? funeral Manger of Death 28b. Time of 28d. Describe how injury occurred After 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 No investigation death. s after death completely filled in by the 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funeral C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[Medical Examiner: On the basis of examination and/or investigation in examination death.] 29a. Certifie Medical (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certified 30. Name and death (Item 23a) (Type, Print) BELVEDENE AVE. BALTMONE MD 21215 0 31. Date filed (Month, Day) 32. Res ar's Signature

DHMH 17 Rev 1/2001

State Registrar

State of Maryland / Department of Health and Mental Hygien 2 0 0 1 36919 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year **Physician**)OHNSON 22:09 M BEVERLY 2004 NOVEMBER 15 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner THE JOHN'S HOPKINS BAYVIEW MEDICAL CENTER Baltimore

7 Age (In vrs. last birthday) If Under 1 Year | If Under 24 Hrs. Baltimore City N/A 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 ☐ M 2√□ F Yrs. Director 215-32-9188 68 Maryland Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location 28e-f show in than "netural", or Items 23a or 28e-f show The Medical Examinating Legicality at 1 Yes 21 No Baltimore Edgemere Maryland Directo 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21219 United States 7728 North Point Road 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Yes 3/1 No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: þ 3 ☐ Widowed 4 ☑ Divorced White 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15 Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) is marked other than College (1-4or 5+) Elementary/Secondary (0-12) Verizion Telephone Operator 9 Years 17. Father's Name (First, Middle, Last) 18 Mother's Name (First Middle Maiden Sumame) should be f nd Mental 8 Margaret Joyce Louis Markel 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 st ment of Health and ant: If itam 27 ts r 21222 Daughter 7954 St. Bridget Lane Dundalk, Maryland Denise Loughry Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1

■ Burial 2 □ Cremation 3 □ Removal from State permit. Page Department of Important: If any Injury or once. A Donation 5 ☐ Other (Specify) Parkwood Cemetery 11/18/2004 Baltimore, Maryland 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 2122 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final a. MULTI-SYSTEM ORGAN FAILURE 2 weeks **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner LSCHEMIC COLITI month Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): certificate be executed use as the burial-transit that initiated events attending physician and resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month Year in the past 12 months? Day 4 Pregnant at time of death 5 Other (specify) signed by the a P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I à Division of Vital Records, 2 No 3 Probably 4 □Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autonsy perform 1 ☐ Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be examiner' Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🗙 No Certification: To this 28c. Injury at Work? 27. Manner of Death Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation Director: the 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 5 24 hours a Hospital 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medicai (Check only one) and manner stated the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 0 2 RES-000 VOV. 15, 2004 -mD 10_ 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WEISS POBOK 110 TOWER 600 NORTH WOLFE STREET, BALTIMORE, MD 21287 31. Date filed (Month, Day, Year) 32. Registrar's Signature State NOV22 Senera 2004 Registrar

			For State Registrar	State of M	faryland / [rtment of H		and Mental	Hygiene	2001.	36920			
	Physici	an	1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year 3. Ti												
	/Medic	al	4a. Facility Name (If not institution, giv	JAMIES e street and number			4b. City, Town, or	Location of	Nove:		County of Dea	112			
	Examin	er	Northwest Hospit	al Center	•		Randal	lsto	vn.		Baltin				
	Funeral Director		5. Social Security Number 6. S 216-24-9918	Gex 7. A	nge (In yrs. last bir 76	rthday) Yrs.	Months Days	If Under: Hours	Min. (Monti	of Birth h, <i>Day</i> , Year, 29 , 19	9. Bir 0.28	thplace (State or Foreign ountry) MD			
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	or 28a	Director	106. Street and Number 10f. Zip Code									ountry?			
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d 2	illed v I Hygie other t	0	12 17. Father's Name (First, Middle, Last)		Sec	retary	18. Mothe	r's Name (First, Mi			sics Lab			
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Mar	s 1 and 2 should f Health and Mer item 27 Is marke other traumatic		19a. Informant's Name/Relationship		la la				South F						
ore,	00		Michelle M. James Daughter 3604 Sprigg Street South, Frederick, MD 21704 20a. Method of Disposition 1 Aburial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cernetery, crematory or other place)												
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	Pnysician /Medical		Immediate Cause (Final disease or condition resulting in death)	a	s a casequence	Z12	5					DAYS			
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	nsit	miner	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease of illury)									31			
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	To th withir To th comp	Me	29b. Signature and title of certifier	P. mel	la mo	`	29c. License		3		te signed (Moni	11			
	- >		30. Name and address of person who				Print) la Gu	,	2 P mes		inher 17	7 2014.			
_	10		MARTH WEST	HISPITAL	- PEN				LSTOWN		211	33.			
•	Sta Regist		31. Date filed (Month, Day, Year) NOV 2 2 2004	2. Regis	strar's Signature.	14	park								

State of Maryland / Department of Health and Mental Hygiene [] [] [Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** 17, 2004 Lynette Lynnette James NOV. 0858 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner LIBERTY ROAD AT DEER PARK BALTIMORE RANDALLSTOWN 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9 Birthplace (State or Foreign **Funeral** 1 ☐ M 2 💢 F 42 Yrs Washington, DO Director 577-90-1072 Usual Residence of Decedent 10c. City, Town or Location worle 10d. Inside City Limits r than "natural", or Items 23a or 28a-1 ehov the Medical Examiner must be notified at YOYes 2 □ No Director Randallstown Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 4247 Herrea Ct. 21133-1221 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: Black 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filed within Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 4 Homemaker -Accountant <u>Home</u> other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be filk Department of Health and Mental Hy Important: If item 27 is marked othen any injury or other traumatic event Harry L. Moore Rupearl Moore19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 4247 Herrea Ct, Randallstowne, Md. Rev. Therm James Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Durial 2 Cremation 3 Removal from State ¹ 4 □ Donation 5 □ Other (Specify) Woodlawn Cem. 11-23-04 Baltimore, Md. 21. Signature of Funeral Service Licensee
Lloyd M. Estep 22. Name and Address of Facility Estep Brothers Funeral Ser,P.A. 1300 Eutaw Place,Baltimore,Md.21217 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Multyl Priysician /Medical Due to (or as a consequence of **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner burial-transit Due to (or as a consequence of): the attending physician Physician/Medical as the t IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4 Pregnant at time of death 5 Other (specify) P.0. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 \[\] No 24a. Was an autopsy performed? Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6XOther (Specify) AT SCENE 1 X Yes 2 ☐ No 28d. Discribe how injury occurred subject 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Certification: Injury JAM pelestion struck by webich Natural 5 Pending death. 1 ☐ Yes 2 No 2 Accident 3 Suicide investigation 11/17/04 Hospital or Attendi 24 hours after death Funeral Director; A 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Deer Park, Belling Noo 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) and manner stated. To the within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E NOV. 18, 2004 beofin M. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201 THE WORE MIKING 31. Date filed (Month NOV 2 2 32. Registrar's Signature State 2004

Registrar

		For State Registrar	tate of Maryland	-	rtment tificate			nd M		giene Reg. No.2	004	369	122
Physicia /Medic		1. Decedent's Name (First, Middle, Last) VERONICA To	HNSON						2. Date of De Month	Day	2004	3. Time of I	
Examin		4a. Facility Name (If not institution, give street MERCY MEDICAL C	_			LTIA	JORE	2	ITY		nty of Death		
Funeral Director		5. Social Security Number 6. Sex 1 M	7. Age (In yrs. las 2 ☐ F 43	t birthday) Yrs.	If Under 1 Months	Year Days	If Under 2 Hours	Min.	8. Date of Bird (Month, Da 11-3-	th y, Year) -61	9. Birth	place (State or ntry) Md.	Foreign
e Maryland 3e-f show	ctor	Usual Residence of Decedent 10a. State 10b. County NA	10c. City, 1		timore		_					10d. Inside City 1 X Yes	
with th	II Dire	10e. Street and Number 1109 Willinger Ct.		10f. Zip	Code L202					10g. Citizen of What Country? USA			
s 1 and 2 should be filed within 72 hours after death with the Maryland af Healith and Membal Hygiene. If Healith and Membal Hygiene. Other treumatic event, It's Medical Exaction treumatic event, It's Medical Exaction to the restriction.	by Funeral Director	11. Marital Status 12. 1文 Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced		Vas Decede f Yes, speci l ☐ Yes	_	panic Orig , Mexican Specify:	jin? (Spe , Puerto I	cify Yes or No Rican, etc.)		Race - Ameri Black, White, acify: B.			
hin 72 hour s. in "neturel	Completed t	15. Decedent's Educati (Specify only highest grade co		(Give	dent's Usual kind ol work DO NOT use	k done du	tion uring most	of workii	ng		f Business/Ir		
filed with Hygiene. other than		12th grade 17. Father's Name (First, Middle, Last)	rs	Comp	uter	Anal		r's Name	(First, Middle,			tjer &	Howar
arked oth	To Be	Israel	Johnso	on			Ma				erson		
1 and 2 should Health and Men tem 27 Is marke		19a. Informant's Name/Relationship (Type, Bettie Peterson 20a. Method of Disposition	Cousin	110		ling		., E	Route Number Baltimo	re, Md		02	
Pages 1 nent of H int: If ite ury or ot		1 Burial 2 □ Cremation 3 □ Rem 4 □ Donation 5 □ Other (Specify)	oval from State	netery, cren	matory or of	her place			6-04		el, Md		
permit. Pages Department of h Importent: If ite any injury or of		21. Signature of Funeral Service Licensee	() 22	March	d Address	s of Facility	у	Balti	imore, E. Nort	Md.	21202		
Physician /Medical pe executed /Medical Examiner and stree private it as the private	Ilcal Examiner	23a. Part1. Enter the disease, or complicate shock, or heart failure. List only one of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last d	ause on each line.	A YELO nce of):	OLD (Interval Betwonset and D	Death
death cert e attendin id for use	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 moprths? 1								Date of deliv Month	-	ear ear	
sign d be	þ	1 Types 2 PMO 3 T Probably 4 TIL											
The law ate has b	Completed	24a. Was an autopsy finding autopsy performed? Types 2 No 1 Yes 2 No									empletion of ca	available ause of	
Physicien: This certificate ral director, p	o Be	25. Was case referred to medical examiner? 1 Yes 2 No Hos	pital: 1 ☑Inpatient 2 ☐ El	R/Outpatier	nt 3 DO	A Othe	-		n <i>(Check only o</i> me 5 ☐ Resi		Other (Speci	(v)	
e de de de de de de de de de de de de de	-	27. Manner of Death 1 Statural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	8b. Time o Injury	f 2	8c. Injury Work 1 🗆 Y		No	28d. Describe	how injury oc	curred		
To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the fune funered.	Certification:	4 Homicide determined	28e. Place of Injury - At hom building, etc. (Specify)						28f. Location (City or To	wn, State)			per,
the Hosp nin 24 hou the Fune npletely fil	Medical	(Check only 2 Medical Examiner one)	ian: To the best of my knowl : On the basis of examination and manner stated.	edge, deat on and/or in	vestigation,	at the tim in my op	inion, dea	d place, th occurr	and due to the ed at the time,	date and pla	ce, and due t	o the cause(s)
To with	~	29b. Signature and title of certifier				DOC	0617			NOVEMI	BER 2	0,2004	
10		30. Name and address of person who comp	= 300, Tower bu	23a) (Type,	Print) Merc	y ME	VICAL	Cent	301	ST PAUC	PLACE	BACTO,	1021201
Sta Regist		31. Date filed (Month, Day, Year) NOV 2 2 2004	32. Registrar's Signatu	G	Spor	Kel							

B.K.S RONNI	S E JENKI	INS	Please	Type or Prin								_		
			For State Registrar	State of Ma	aryland /	Depa <i>Cer</i>	irtment of F <i>tificate of</i>	lealth and N <i>Death</i>	lental Hy	/gien		36923		
			1. Decedent's Name (First, Middle, L	ast)					2. Date of D Month		3. Time of Death			
	Physicia /Medic		Roppie James Jorland											
덱	Examin		4a. Facility Name (If not institution, gr 12184 NEBEL STI	ive street and number) REET			4b. City, Town, o	r Location of Death		4c. County of Death MONTGOMERY				
Ī	Funeral Director		5. Social Security Number 6. 217-68-7175									thplace (State or Foreign buntry) nessee)	
	P		Usual Residence of Decedent		10c. City, To		estica					10d. Inside City Limits	_	
	Marylar F show	tor	10a. State 10b. County Maryland Montgor	mery	Germa							1 ☐ Yes 2 🎇 No		
	n the	Director	10e. Street and Number 10f. Zip Code 10g. Citizen of What C									ountry?		
	th with	al D	20800 Amber Hill	ber Hill Court 20874 Un							ted Stai	tes		
	ems ems	Iner	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S.	13. \	Vas Decedent of I	lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or N Rican, etc.)	0-	14. Race - Ame Black, Whit			
036	72 hours after death with the Maryland natural', or Items 23a or 28a-f show dieal Exactinate and illed at	by Fu	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 📉 N If Yes, Give Year or Dates:	No	I□Yes 2∏ No	Specify:	Specify: Wh	^{gcify:} White					
2-0	72 ho	eted	15. Decedent's (Specify only highest g	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. Do NOT use retired)							16b. Kind of Business/Indi			
Baltimore, Maryland 21215-0036	d within giene. er than "	Completed by Funeral	Elementary/Secondary (0-12)	College (1-4or 5		Owne					lass Company		_	
pue	be file ntal Hy ed othe	Be	17. Father's Name (First, Middle, Last)								n Sumame)			
<u> </u>	ss 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hygiene. Item 27 is marked other than "natural", or Items 23a or 28a-f show ther traumatic event, the Madical Exacultur coust be notified at	٦	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zi										-	
Ma			Donna Jo La Tora/Representative 24400 Club View Dr., Damascus, Maryland 20872											
Je,	of Hez item item		20a. Method of Disposition		20h Place	of Dieno	cition (Name of	cal	Date		ocation - City or		Ī	
<u>ii</u>	Page ment ant: If ury or		20a. Method of Disposition 1 □ Burial 2 M Cremation 3 □ Removal from State 1 □ Donation 5 □ Other (Specify) 1 □ Donation 5 □ Other (Specify) 1 □ Donation 5 □ Other (Specify) 1 □ Burial 2 M Cremation 3 □ Removal from State of Montgomery 1 □ Crematorium Inc. 21, 2004 200. Escalation only of Tolkin, State of Montgomery 21, 2004 21, 2004 21, 2004											
Balt	permit. Pages 'Department of H Important: If ite any Injury or ot		21. Signature of Funeral Service Liv		M01353	Ro Ro	Name and Address ockville, ockville	ess of Facility Rob Inc. 300 Maryland	ert A.) West 1 20850	Pum Mont -280	phrey Fu gomery A 5	ineral Home, Avenue	/	
			23a. Part1. Enter the disease, or co shock, or heart failure. List on	mplications that caused by one cause on each li	d the death. [Approximate Interval Between		
	Pnysician		Immediate Cause (Final disease or condition	. N-	eck	II	rur	4				Onset and Death		
	/Medical Examiner		resulting in death)	Due to (or as	a consequen	ce <i>o</i> f):	9	1						
- 1	LAGIIIIICI	ii.	Sequentially list conditions, if any, leading to immediate	b Due to (or as	a consequen	ce of):							_	
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Box 68760	icate be e physiciar s the buri	IIcal		d										
9 ×	ertific ding p	/Mec	IF FEMALE:	23c. If yes, outcome	of pregnancy	,					23d. Date of de	livon		
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	uires that t signed by d be deta	þ	Part II. Other significant conditions	s contributing to death b	out not resulting	ng in the u	nderlying cause gi	ven in Part I.			1/	o the cause of death?	١	
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I Re	The lavate has	Com							1 Yes	formed?	death?			
/ita	Physician: Th r this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:			01	26. Place of Dea						
of	hys this al dii	2	1 X Yes 2 □ No 27. Manner of Death	1 Inpatio	ent 2□ER	Outpatier	II 3 DOA	4 Nursing H	ome 5 Re: 28d. Describe			ocity) AT SCENE	<u></u>	
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Division of Vital Records,	i gite o	Certifications	3 Suicide 6 Could not be determined 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Months of Street) City or Town, State)							and Number or R	H Nebelst	-		
	Hospital 24 hours a Funeral I stely filled	dical (Physicien: To the best aminer: On the basis of	of examination									

CALOLH. ALLAN
31. Date filed (Month, Day, Year) State Registrar

NOV 2 2 2004

32. Registrar's Signature

29b. Signature and title of certifier

29c. License number O.C.M.E

29d. Date signed (Month, Day, Year)

NOV. 14, 2004

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 004 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** 6:15 AM 2004 arangelen NOVEMBER /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country)
MARYLAUD 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) 6. Sex 5. Social Security Number **Funeral** Days Hours Min 10 M 20 F Months -05-6085 Yrs 12-24-15 Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b County ral', or iteme 23a or 28a-f ehow Exerciner natal be notified at 1 Yes 2 No Director ton 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1921 2 AVEN death v Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 MYes 2 ☐ No If #es, Give 11. Marital Status 1 and 2 should be filed within 72 hours after Health and Mental Hygiene. tem 27 is marked other than "natural", or ite ther traumatic event, the Medical Externinal 1 Never Married 2 Married 1 Yes 2 No Baltimore, Maryland 21215-0036 Specify. þ 3 ☐ Widowed 4 ☐ Divorced ear or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Drount 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be aranap ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) AVEN Ikton If item 27 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition Pages 1 1 ☐ Burial 2 ☐ Cremation 3 Removal from State permit. Page Department o important: If eny injury or once. Memorial Cardas 11-20-04 4 □Donation 5 □ Other (Specify) 22. Name and Address of Facility 3 NEW POICT 21. Signature of Funeral Service Licensee FOR nota CHAPEL-BEL EVANS FUNERAL 23a. Part1. Enter the dissues, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List enty one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) DEMENTA THEATLET Physician /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Dicease or ir july that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospital or Attanding Physician: The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, altending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 3 Probably CENERROUNS CULON_ ACCIDENT 1 ☐ Yes 2 ☐ No 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an MATTER PROPOSICIO page 2 autopsy performed? 2 DL No. certificate DIABETES MELTY 1 Yes 25 No 1 Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 2 1 Yes 2 No 3 DOA After this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation after death Director: filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 28l. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide within 24 hours a To the Funeral C 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical one) To the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of H2B412 HOURMBEN 17, 2004 completed cause of death (Item 23a) (Type, Print) 30 Name and address of person who HAVANATAL (1881 MAHIO DO 132 Pegistrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year **Physician** KIDD 12:00PM JOHA FRANCIS OVEMBE 19.2004 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Baltimore Saint Joseph Medical Towson Center If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Days 1∭2 M 2□ F MARYLA Director 220-14-3800 Usual Residence of Decedent 72 hours after death with the Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits itam 27 is marked other than "natural", or itams 23a or 28a-f show other traumatic avant, the Medical Examinar must be notified at 1 Yes 2 No Director MARYLAND BALTITORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? N.S.A 1AKINGTON 21030 Completed by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. 11 Marital Status Black, White, etc. 1 Yes 2 □ No If Yes, Give Year or Dates: 1 Never Married 250 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced STIHW 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Pages 1 and 2 should be filed within inent of Health and Mental Hygiene. ant: If itam 27 is marked other than " Elementary/Secondary (0-12) College (1-4or 5+) A O ANDERSOR BARBER 137RS 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be K,00 MAILLIC SAILADAI 0 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 101412 HARINGTON 16000 Merchano 00/0825 20b. Place of Disposition (Name of commentary or other place)

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20c. Date of Date of Commentary or other place of Commentary or other place of Commentary or other place of Commentary or other place or other place of Commentary or other place of Comm 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State ō permit. Page Department o Important: If any injury or (BRY LEW) * 4 ☐ Donation 5 ☐ Other (Specify) FORZZT HUL 21. Signature of Euneral Bervice Licensee ANDERSTATION LINTER (NE 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** OCULTE MYOCARDIAL INFARCTION HOURS /Medical Due to (or as a consequence of): Examiner SHOCK Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner law requires that the death certificate be executed as the burial-tran Due to (or as a consequence of): Box 68760, nding physician Physician/Medical IF FEMALE: esn 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ō Month Day Year in the past 12 months? 4☐ Pregnant at time of death 5 Other (specify) the. □Yas 2□No Ö 9 Unknown detach ģ ۵. 23e. Did tobacco use contribute to the cause of death? signed to Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Munknown CIRRHOSIS peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an ABDOMINAL AORTIC ANEURYSM page 2 s autopsy 2 No certificate 1 ☐ Yes of Vital director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 X ER/Outpatient 3 ☐ DOA 2 this 27. Manner of Math 28b. Time of 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28c. Injury at Work? After t Certification: Division To tha Hospital or Attanding 5 Pending investigation 1 XNatural 1 ☐ Yes 2 ☐ No death. ☐ Accident Diractor: / 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 T Homicide hours after within 24 hours a To tha Funeral D 29a. Certifier To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number 26002 e of death (Item 23a) (Type, Print) 30. Name and address of person who complete 76 (1) 1 Signature -M. D. TOWSON MARYLAND 21204 State DOCK. Registrar

		1	For Stete Registrar	State of Maryland		artment of H tificate of L		•	giene Reg. No.	004	36927	
			Decedent's Name (First, Middle, Last)				2, Date of De Month	ath Day	Year	3. Time of Death	
	Physicia /Medic		REGINA MARIE B	OONE KNELL				NOVEMB		20, 2004 11:00 A		
	Examin		4a. Facility Name (If not institution, give Saint Joseph	4b. City, Town, or		Death WSON	4c. County of Death Baltimore					
	Funeral		5. Social Security Number 6. Se	THE ONE		If Under 1 Year Months Days	If Under 24 Hours	Min. (Month, Da	ıy, Year)	Cou	place (State or Foreign intry)	
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	land ow		10a. State 10b. County	10c. City,	Town or Lo	cation					10d. Inside City Limits	
	Mary -1 sh	ţ	Maryland Baltimor	e County	Roc	dgers For	ge				1 ☐ Yes 2 ☐ No	
	r 288	irec	10e. Street and Number	0 000.10)		10f. Zip Code	<u> </u>		10g. Citize	n of What Cou	intry?	
	th wil	ai	330 Murdock Road				212			USA		
	r dea	Funeral Director	11. Marital Status	12. Was Decedent Ever in U.S Armed Forces?	13.	Was Decedent of Hi f Yes, specify Cuba	spanic Origir n, Mexican, F	n? (Specify Yes or No Puerto Rican, etc.)	- 14	 Race - Amer Black, White 		
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Mai	12 sh h and 7 Is n treun	ı	19a. Informant's Name/Relationship (7)									
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nor			1 XBurial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Removal from State	•	natory or other plac		1/23/2004	Dol+	i. oro	Maryland	
Baltimore,	permit. Page Department of Importent: If any injury or once.	l	21. Signatu of Tune I Service Li	LOU	22	. Name and Address	s of Facility					
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			Martin D. La 23a. Part1. Enter the disease, or comp shock, or heart failure. List only	one cause on each line.	Do not ent	er the mode of dyin	g, such as ca	irdiac or respiratory a	rest,	yranu z	MICOLAGI DOCTAGOLI	
	Physician /Medical Examiner		Immediate Cause (Final disease or condition LUNG CANCER									
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Вох	eath certific attending p I for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnan 1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of deal	death 3	Ectopic pregnancy Other (specify)			23d. Date of deliver		very Day Year	
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•	: ^		lba	lo my		pet	886		Nov.	20-3	2004	
	W		30. Name and address of person who	completed cause of death (Item	23а) (Туре,	Print)					m. m. /	
1			31 Date filed (Month Day Year)	5 M.D. 76.71 32. Registrar's Signati		ER DRIV	E, TO	OWSON. MA	ARYLF	IND 21	204	
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		-	For State Registrar	State of	Marylan		artment of H		and Mental H	ygiene Reg. No.		369	28
	Physici		1. Decedent's Name (First, Midd						2. Date of D Month	Dav	Year	3. Time of De	
	/Medic	al	Charles F. Ke		oer)		4b. City, Town, or	r Location o			2004 County of Death	8:15	A
	Examin	er	4480 Doncaste		·		Ellicot	t Cit	у		Howard	d	
	. Funeral		5. Social Security Number	6. Sex 7.	Age (In yrs. I		If Under 1 Year Months Days	If Under : Hours	Min. (Month, I	Day, Ye <i>ar)</i>	Cou	place (State or F ntry)	-oreign
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	or 28	Director	10e. Street and Number 10f. Zip Code							10g. Citize	. Citizen of What Country?		
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21215-0036	within 72 hours after death with the Maryland ene. than "natural", or Itama 23c or 28a-f ahow the Modical Exavilher is ust be notified at	þ	3 Widowed 4 Divorce		1 ☐ Yes 2X No	Specify:			Specify: White				
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9 x	death certific e attending pl od for use as t	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outc	ome of pregna	ancy				2:	3d. Date of deliv	rery	
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Div	i or Attand after death Diractor: d in by the	Certification;	4 Homicide		g, etc. (Specif		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		City or 1	Town, State)			
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ĺ	101		30. Name and address of person	FERRE		n 23a) (Type	Print) 76	110	80 Belgir i MD	2123	·6=		
g 4	St Regist	ate rar	31. Date filed (Month Pay Yes	2 2004 32. Re	gistrar's Signa	ature	Son	100					

State of Maryland / Department of Health and Mental Hygienes 36929 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 6:558 **Physician** Adolf Koas /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Stella Maris at Mercy Medical Baltimore n/a Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year, 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Months Davs Hours 10XM 2□ F 85 168-18-0584 June 19, 1919 Pennsylvania Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10h County or 28a-f show traumatic event, the Mudical Examiner must be notified at 1 ☐ Yes 2 [XNo Marion Directo Florida Summerfield 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 5055 S. E. 137th Place 34491 Itams 23a USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? XYes 2 ☐ No Yes. Give 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 "natural", or 1 ☐ Yes 2 X No Specify. Specify: WW II White Completed by 3 MWidowed 4 □ Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 72 c. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "na any injury or other traumatic event, If a Mudic once. College (1-4or 5+) Elementary/Secondary (0-12) Eastern Airlines Mechanic 12 n/a 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Koas Anna Misiewicz Stanley ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) Mr. Nicholas Koas (Son) 1202 S. Streeper Street Baltimore, Maryland 21224 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Hilltop Service Corporation 11/23/2004 Towson Maryland 51 Other (Specify) ⁴ 4 □ Donation 22. Name and Address of Facility 21. Signature of Leonard J. Ruck, Inc. 5305 Harford Road Balto. Md. 21214 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final VNG Physician disease or condition resulting in death) canes /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause full sase or injury that initiated events Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-transit the attending physician and ned for use as the burial-tran resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 4 Pregnant at time of death 5 Other (specify) P.O. detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Division of Vital Records, page 2 should be 3 Probably 4 □Unknown 1 ☐ Yes 2 ☐ No Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 2₽No or Attending Physician: funeral director, 26. Place of Death Check on one 25. Was case referred to medical examiner' Hospital: 1 Inpatient Other: 4 □ Nursing Home 5 □ Residence 6 ØOther (Specify) \ CSacc 1 Yes 2 No 2 ER/Outpatient 3 DOA Certification: To this 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death After 1 Natural 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A investigation 2 Accident the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide 29a. Certifier 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certified 12004 40854 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 15Y iltimore Riseberg 2004 32 Registrare Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** November 17, 2004 9:00 PM Phyllis Jeanne Kohlhoff /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a Fecility Name (If not institution, give street and number) Examiner 2917 Dunmerry Road, Apt. A Baltimore Dundalk If Under 24 Hrs. Hours Min. If Under 1 Year Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Months 1 M 2 F 67 Yrs. Director 317-34-0805 Aug 13, 1937 Indiana Usual Residence of Decedent filed within 72 hours efter deeth with the Meryland Hyglene.
ther than "natural", or items 23s or 28s-f show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location or itama 23a or 28a-f sho 1 ☐ Yes 2 No Funeral Director Baltimore Dundalk 10g. Citizen of Whet Country? 10f. Zip Code 10e. Street end Number 21222 United States 2917 Dunmerry Road, Apt. A 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 1 Never Married 2 Married 1 ☐ Yes 2 No Baitimore, Maryiand 21215-0020 1 Yes 2 No Specify: 3 ☐ Widowed 4 🗷 Divorced Be Completed by White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Health Care Elementary/Secondary (0-12) College (1-4or 5+) Nursing Assistant 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Peges 1 end 2 should be l Depertment of Heelth end Mentel I mportant: If Itam 27 is marked or William Kerby Onda Bollinger 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2917 Dunmerry Road, Apt. A, Dundalk, MD 21222 Ms. Anne Payne/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 MCremation 3 ☐ Removal from State Nov 19 4 ☐ Donation 5 ☐ Other (Specify) Beltsville, MD Chesapeake Crematory 2004 22. Name and Address of Facility
Cremation and Funeral Alternatives 21. Signature of Funeral Service, Licenses M00986 8717 Green Pastures Drive Baltimore, MD 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Physician/Medical Examine Physician: The lew requires that the deeth certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initioled events resulting in death) Last Due to (or es e consequence of) Division of Vital Records, P.O. Box 68760. Due to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown Completed by 24b. Were autopsy findings available prior to completion of cause of deeth? 24a. Was an autopsy performed? 1 ☐ Yes 2 🕶 1 Yes 2 No 26. Place of Death (Check only one) B 25. Was case referred to medical examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home Medical Certification: To 1 Yes 2€No 3□ DOA 5 Residence 6 □Other (Specify) this 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 Pending investigation Iniun 1 Natural I Diractor: Af 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 - Homicide ò To the Hospital within 24 hours a To the Funeral Completely filled Medicat Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medicat Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and little of certifier th (Item 23e) (Type, Print) 31. Date filed (Month, Day, Year) 32. Registrer's Signature State NOV 2 0 2004 Registrar

Conthoff, Phyllis

04-06492 UNK 04-330 RJ HANSON KOO

Amend Items 7,8,9,10a-g,12,13,15,16a,b,20b per th 3845 7-16-Inpend Item 238,12,01 per the 3845 7-16-Inpend Item 238,10t of Maryland Department of Health and Mental Hygiene

For Unpend Item 23a, pt.11,27 per Registrar 36931 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** Hanson Koo October | 8. 2004 10:10 A. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 12923 Poppyseed Court Montgomery County

9. Birthplace (State of Foreign Country) China Germantown If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In vrs. last birthday) 5. Social Security Number 8. 2ate at Bro 35 **Funeral** 1 □XM 2 □ F (Unknown) 69 Director Usual Residence of Decedent the Maryland 10a. State Unknown) 10c. City, Town or Location (Unknown) 10d. Inside City Limits 28a-f show the Madical Examiner must be notified at 1 ☐ Yes 2 ☐ No Director Montgomery Germantown known 10f. Zip Code (Unknown) 10g. Citizen of What Country? 10e. Street and Number (Unknown) 5 20877 238 U.S.A. 12023 Poppyseed Ct. Funeral (Unknown)

12. Was Decedent Eyer in U.S.
Armed Forces? Unknown

1 | Yes 22 | No
If Yes, Give
Year or Dates: Items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after Hygiene. other than "natural", or ite Asian 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: by Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) (Unk) (Unknown) Physician Medicine (Unknown other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 1 and 2 should ba fi Health and Mental Hem 27 Is markad ot (Unknown) (Unknown) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 I Helen Yen Koo / Aunt 5310 Danbury Rd., Bethesda, MD 20814 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition (Unk Pate 20c. Location - City or Town, State permit. Pagas 1
Department of He
Important: If iten
any Injury or oth 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Beltsville, MD Chesapeake Crematory 12-11-04 ' 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fuperal Service Licensee 22. Name and Address of Facility Rapp Funeral and Cremation Services Mple Johnson 23a. Part1. Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Atherosclerotic Cardiovascular Disease disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine requires that the death certificate be executed use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 Physician/Medical attending phys IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4☐ Pregnant at time of death 5 Other (specify) Records, P.O. 1 ☐ Yes 2 ☐ No detached 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ should be Diabetes Melliltus (clinical history) 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Honknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

Yes 2 \sum No 24a. Was an 1 Yes 2 No Division of Vital Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Nother (Specify) 1X Yes 2 □ No 1 Inpatient 2 ER/Outpatient 3 DOA 2 At scene funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After Injury 1 Natural 2 Accident 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Diractor: A investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 | Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical XXMedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number **OCME** October 09, 2004 out 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

HANGARE AD CORECTION Street, Baltimore, Maryland 21201 HAVY A RE TO 31. Date filed (Month, Day, Year) . Registrar's Signature State NOV 2 0 2004 Registrar

State of Maryland / Department of Health and Mental Hygien 36932 Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) DWIGHT LYNN LAVINDER Month **Physician** 6:45 2004 20. Nov. /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Linthicum Anne Arundel Hospice of the Chesapeake Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year, Oct 13, 1 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days 1[XM 2□ F Vrs Ĩ'951 53 Maryland 220-56-1186 Director Usual Residence of Decedent 10d. Inside City Limits the Maryland 10c. City. Town or Location 10b. County 10a. State 28a-f show event, the Medical Exercicer must be notified at 1 ☐ Yes 2 No Pasadena Maryland Anne Arundel Directo 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 7612 Beach Drive 21122 ò USA or itams 23a death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. tiled within 72 hours after 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 No Specify: Baltimore, Maryland 21215-0036 Specify: White þ 3 Widowed 4 Divorced 'natural', Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Mayy Us Government than Elementary/Secondary (0-12) College (1-4or 5+) Technical Designer Dept. of Defense other 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be tile Depertment of Health and Mental Hy, Importent: If Item 27 is marked other any injury or other treumatic event 17. Father's Name (First, Middle, Last) Alfred T. Lavinder Dorothy L. Lantz 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) (WIFE) Gloria G. Lavinder 7612 Beach Drive, Pasadena, Md. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Bayview Crematory, Inc. 11/22/04 Baltimore, Maryland `4 □Donation 5 □ Other (Specify) 21. Signature of Funeral Service Icensee Kevin E Ecker 22. Name and Address of Facility McCully-Polyniak Funeral Home, P.A. 3204 Mountain Rd., Pasadena, Md. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of). **Examiner** Sequentially list conditions. Sequentially list conditions, r any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examine or Attending Physician: The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of) P.O. Box 68760. physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Month Day Year 4☐Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown ate has been signed by page 2 should be detacl 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. Completed by 1 ☐ Yes 2 ☐ No 3 Probably 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 22 No this certificate has 2 No 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 2 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Certification: After 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No death. after death 2 Accident the 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 24 hours a Hospital Karatrying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier person who completed cause of death (Item 23a) (Type. P ho 3 31. Date filed (Month) 32. Rigistrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygien 36933 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Vear **Physician** 7:12 PM MARY ANGELA LACEY NOVEMBER 20 2004 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner OWSON Center Saint Joseph Medical If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex **Funeral** Months 1 M 2 F 212-20-8256 80 16/1924 MARYLAND Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County Item 27 is marked other then "netural", or Items 23a or 28e-1 show other treumetic event, Inc Medical Exarting the multiple at MD TOWSON 1 ☐ Yes 2 ☐XNo BALTIMORE Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1537 DELLSWAY ROAD 21286 USA Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes 2 MNo If Yes, Give 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: SpecifyWHITE 3 ☐ Widowed 4 ☐ Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry other then " Elementary/Secondary (0-12) Callege (1-4or 5+) OWN HOME 12TH GRADE HOMEMAKER 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be 1 and 2 should be fi Health and Mental H FRANCIS ANTHONY DOYLE REGINA HOLDEN 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1537 DELLSWAY ROAD TOWSON, MD 21286 LAWRENCE R. LACEY HUSBAND Health Item 27 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a, Method of Disposition Department of H Importent: If Ite any injury or of once. DULANEY VALLEY MEM. 1 ☑ Buriai 2 ☐ Cremation 3 ☐ Removal from State 11/24/2004 COCKEYSVILLE, MD 4 □ Donalion 5 □ Other (Specify) GARDENS 22. Name and Address of Facility THE JOHNSON FUNERAL HOME, P.A. 21. Signature of Funeral Service Licensee 8521 LOCH RAVEN BLVD. TOWSON, MD 21286 And a Enter the disease, or explications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate
Interval Between
Onset and Death
30 HUURS Immediate Cause (Final MITRAL VALVE PAPILLARY MUSCLE **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): ARTERIOSCLEROTIC CORONARY ARTERY DISEASE YEARS **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner death certificate be executed burial-transit Due to (or as a consequence of): attending physicien Physician/Medical as the IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months?
1 Yes 2 No ŏ 4☐Pregnant at time of death 5 Other (specify) ed by the a detached f 9 Unknown signed b 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Tes 2X No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performe 1 ☐ Yes 2 ☐ No 2 X No certificate 25. Was case referred to medical 26. Place of Death (Check only one) director examiner Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 2 2 X No this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification; After Hospitel or Attending 5 Pending investigation 1 X Natural 1 ☐ Yes 2 ☐ No death. 2 Accident Director: 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined filled in by 4 Homicide within 24 hours a To the Funerel C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D 38655 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

31. Date filed (Month, Day, Year) NOV 2 2 2004

STEWART



5 Sparks

TOWSON.

MARYLAND 21204

Baltimore, Maryland 21215-0036

P.O.

Division of Vital Records,

State of Maryland / Department of Health and Mental Hygien [] 1 36934 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** Ha (se) 2135 M Ĺi 2004 15 /Medical 4b. City, Town, or Location of Death 4a. Fecility Name (If not institution, give street and number) 4c. County of Death **Examiner** Johns Hepkins Bayview Medical 5. Social Security Number W. E. Sey 7. Age (In yrs. last bi Baltimore Baltimore City If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign
Country) 5. Sex 1 1 M 2 □ F **Funeral** Hours Min. Bultimore Director Usual Residence of Decedent death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State r 28e-f show incliffed at 1 Yes 2 No MD Baltimore Essex Direct 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number rel', or items 23e or Everaliser roust be 21221 United States 1703 Earhart Road Funerai Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: filed within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Black Baltimore, Maryland 21215-0036 Specify. ģ 3 ☐ Widowed 4 ☐ Divorced "naturel" 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade com 16b. Kind of Business/Industry completed) N/A Elementary/Secondary (0-12) College (1-4or 5+) N/A 0 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be 1 Department of Health and Mental I Importent: If Item 27 is marked of Curt Love Danita Harrell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ms. Danita Harrell/Mother 1703 Earhart Road, Essex, MD 21221 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20c. Location - City or Town, State Nov 20 è Beltsville, MD 2004 Chesapeake Crematory 1 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22 Name and Address of Facility. Cremation and Funeral Alternatives any in MOO96(1 Hule 8717 Green Pastures Drive Baltimore, MD Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death HEMORRHAGE Immediate Cause (Final INTRAVENTRICULAR Physician 10 day disease or condition resulting in death) /Medical Examiner REMATURE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that in the condition of the condi Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 ☐ Fetal death 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4☐ Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has breater, page 2 s 2 No 1 Yes Hospitel or Attending Physicien: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 Z No 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification; To 1 Inpatient 2 ER/Outpatient 3 DOA this 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After Injury 1 Z Natural 5 Pending 1 ☐ Yes investigation 2 Accident within 24 hours after death To the Funerel Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 12 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) To the I 29b. Signature and title of 29d. Date signed (Month, Day, Year) Altending DO054309 Physician 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4940 Eastern Lawson. towned mo 31. Date filed (Month, Day, Year) 32. Registrar's Signature Registrar

ORIGINAL

		. 11	State Registrar	ate of Marylan		artment of H		nd Mental		ne ,2004	36935
	Physicia /Medic	ın al	1. Decedent's Name (First, Middle, Last) PUSCILLA MF	180N				2. Date Month			5:IUA.M
	Examin Funeral		4a. Facility Name (If not institution, give street Manor Care Nursin 5. Social Security Number 6. Sex	g Home 7. Age (In yrs. I	ast birthday)	4b. City, Town, or TOWS		4 Hrs. R Date	of Birth	4c. County of De Baltin	
	Director		213-26-7252 1□ M : Usual Residence of Decedent 10a. State 10b. County		Yrs.	cation			8',	927 Ma	aryland 10d. Inside City Limits
	th the Maryl or 28e-f sho	irector	Maryland N/A 10e. Street and Number			Balt 10f. Zip Code	imore	=	10g.	Citizen of What C	1 ¼Yes 2 ☐ No Country?
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural; or items 23e or 28e-f show any injury or other treumatic event, the Medical Examinar must be notified at an ance.	by Funeral Director	1 Never Married 2 Married 1	as Decedent Ever in U. med Forces? □Yes 2 ☑No Yes, Give ear or Dates:		21216 Was Decedent of Hi If Yes, specify Cuba		in? (Specify Yes Puerto Rican, etc	or No-	USA 14. Race - Arr Black, Wh Specify: B.	nite, etc.
Maryland 21215-0036	within 72 hour iene. rthan "natural	Completed	15. Decedent's Education (Specify only highest grade con	1	16a. Dece (Give life. Reac	dent's Usual Occupa kind of work done of DO NOT use retired ling Spe	ation furing most (Cial:	of working	Ва	kind of Busines altimore ablic Se	e City
rland 2	ould be filed Mental Hygi tarked other natic event, I	To Be C	17. Father's Name (First, Middle, Last) Rogers Smith				Pr		Μ.	Watkin	
	and 2 sho lealth and h m 27 is ma		19a. Informant's Name/Relationship (Type. F William P. Mason,	2nd	2907		Road		more		land 21216
Baltimore,	permit. Pages 1 Department of H Importent: If ite any injury or ot once.	1	20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Remove 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Liouse		dlawr	osition (Name of matory or other place) Cemete Name and Addres	ry	11/20/0	4 Wo	odlawn	, Maryland uneral Home
Ba	permi Depa Impo any i		23a. Part1 Enter the disease, or complication shock, or heart failure. List only one ca	ns that caused the deat	5	240 Rei	ster	stown R	d Ba	ltimore	Approximate Interval Between
68760,	eath certificate be executed Example and attending physicien and attending physicien and attended at the purial-fransit and attended attended at the purial-fransit and attended at the purial-fransit and attended at the purial-fransit and attended at the purial-fransit and attended att	dicai Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last d	Penal Due to (or as a conseq Due to (or as a conseq Due to (or as a conseq	uence of): Lens uence of):	ficiens	4				Onset and Death
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	w requires that the been signed by th should be detache	ed by Ph	Part II. Other significant conditions contribu	ting to death but not res	ulting in the t	inderlying cause give	en in Part I.	23e.	Did tobac		to the cause of death? Probably 4 □Unknown
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n of				a. Date of Injury (Month, Day Year)	28b. Time of Injury	of 28c. Injun Work	y at k?	28d. Des		injury occurred	
Divisio	Dr.:	ertification:	2 Accident investigation	Be. Place of Injury - At h building, etc. (Specil	ome, farm, st		Yes 2⊡≀	28f. Loca	tion (Stree or Town, S	et and Number or State)	Rural Route Number,
	To the Hospitet or Atti within 24 hours after de To the Funerel Direct completely filled in by the	edical C	29a. Certifier (Check only one) Continue 2 Medicel Exeminer:	n: To the best of my kno On the basis of examina and manner stated.	owledge, dea ition and/or in	th occurred at the tin	ne, date an pinion, deal	d place, and due t th occurred at the	time, date	and place, and d	ue to the cause(s)
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1	11		30. Name and address of person o complete WATER HERNE	ered cause of death (Iter	Ctt	nck L.	+ 6	Jupes	M	> 2108	2_
	Sta Regist		31. Date filed (Month, Day, Year) NOV 2 2 2004	32. Registrar's Signa	ature 4	book	,				

		•	For State Registrar	State of Ma	aryland	/ Depa	rtment of F	lealth : Death	and Me		giene Reg. No.		36936
e e	Physicia /Medic		1. Decedent's Name (First, Middle EVELY M	Merton			4b. City, Town, o	a l a sabias	1	Date of De Month	Day	Year 15 2004 County of Death	
	Examin Funeral Director	er	4a. Fecility Name (If not institution University of M. 5. Social Security Number 237-52=5019 Usual Residence of Decedent	anyland Mcc 6. Sex 7. Ag	dical (e (In yrs. las			nove,	, Mar r 24 Hrs. 8 Min.	Date of Bir (Month, Da	th iv, Year)	N/A	place (State or Foreign
	e Maryland la-f show	ctor	10a. State Maryland N/A	X		timo:							10d. Inside City Limits 1X Yes 2 □ No
	th with the 23a or 28 ust be no	Funeral Director	10e. Street and Number 1202 Clevela	nd Street			10f. Zip Code 2123		,			izen of What Cor USA	
036	be filed within 72 hours after death with the Maryland tal Hygiene d other than "natural", or tems 23a or 28a-f show event, the Medical Eraci, if at most ke notified at	by	11. Marital Status 1 □ Never Married 2 □ Marri 3 ☑ Widowed 4 □ Divorced	12. Was Decedent Armed Forces? 1 □ Yes 2 ☑ N If Yes, Give Year or Dates:			Vas Decedent of H Yes, specify Cuba ☐ Yes 2☐ No			ity Yes or No can, etc.))-	14. Race - Amer Black, White Specify: Bla	, etc.
Maryland 21215-0036	within 72 ho lene. than "natur he Medicul	Completed	15. Decedent (Specify only highes Elementary/Secondary (0-12) 11th grade	t's Education it grade completed) College (1-4or 5	5+)	(Give life. L	ent's Usual Occup kind of work done DO NDT use retired Stress	during mos	st of working	7		ind of Business/I ailor	ndustry
and 2	be de la la la la la la la la la la la la la	Be	17. Father's Name (First, Middle, James C. Crud							First, Middle Tayb		Surname)	
Maryk	s 1 and 2 should be f Heatth and Mental Item 27 is marked o other traumatic eve	То	19a. Informant's Name/Relations Eula Truss/ I	hip (Type, Print)		19b. Mailin	g Address (Street Box 72	and Numb	per or Rural Balti	Route Numb	er, City o	r Town, State, Z ryland	^{ip Code)} 21218
Baltimore,	permit. Pages 1 an Department of Heal Important: If Item 2 any injury or other once.		20a Method of Disposition 1 1 Burial 2 Cremation 4 Donation 5 Other (S)		20b. Pla cer	netery, cren Zion		ry		9/04	Bal		, Maryland
Balt	permit. Pages 'Department of the traportent: If Ite any injury or of once.		21. Signature of Funeral Service	Licensee		52	Name and Addre	sters	town	tman- Rd B	Har Balt	ris Fun imore,	neralHome Md 21215
8760,	Physician /Medical Examiner und physician and physician and the printi-transit	cai Examiner	23a. Part1. Enter the disease, or shock or heart failure. List Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or as	a conseque	VASCU ence of): HTOM ence of):	er the mode of dyin			respiratory a	rrest,		Approximate Interval Between Onset and Death
P.O. Box 68	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant al	2 Fetal c	death 3□	Ectopic pregnanc	у				23d. Date of deli Month	very Day Year
	w requires that to be the signed by should be detail		Part II. Other significant condition DI abetes	ons contributing to death b	out not result	ting in the u	nderlying cause giv	ven in Part	1.	23e. Did		use contribute to	the cause of death?
Division of Vital Records,	: The law req cate has beer page 2 shou	Completed by		tery Diseas	se_					24a. Was auto perfe 1 \(\text{Yes} \)		prior to death?	topsy findings available completion of cause of
f Vita	Physician: Th r this certificate ral director. pag	To Be	25. Was case referred to medica examiner? 1 Yes 2 No	Hospital: Inpatio	ent 2 E	R/Outpatier	it 3□ DOA Ott	hor		<i>Check</i> on <i>ly</i> e 5 ☐ Res		6 □Other (Spec	eify)
o uo	Attending Pr r death. ector: After th by the funeral		27. Manner of Death 1 Natural 5 ☐ Pendir 2 ☐ Accident investi		iry iy Year)	28b. Time of Injury	Wo	ryat ⊮rk?]Yes 2.[3d. Describe	how inju	ry occurred	
Divis	al or Attendi s after death. I Director: A	Certification:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	ained 286. Place of III	jury - At hon tc. (Specify)	ne, farm, str	eet, factory, office		28	3f. Location (City or To			ral Route Number,
	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate his completely (illed in by the funeral director, page	Medical C	(Check only 2 Medical one)	ng Physician: To the best Examiner: On the basis o and manner st	of examination	vledge, deati on and/or in	vestigation, in my	opinion, de	and place, areath occurred	nd due to the	date and	d place, and due	to the cause(s)
	withi To t	∑	26b. Signature and title of certifie	gahlal	e 1	MD	29c. Licens		56157	92		ite signed (Mont)	15, 2004
1	10			who sempleted cause of a									nale MD
	Sta Regist	ate rar	31. Date filed (Month, Day, Year, NOV 2 2 2		rar's Signati	y G	Spork	/					

Piease Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) NOVE MBER 10:05 PM AMES 17,2004 4b. City, Town, or Location of Death 4c. County of Death 4a Fecility Name (If not institution, give street end number) NORMWEST ANDALLITO-NA RAUTIMORE If Under 1 Year Months Days If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Dey, Year) 5. Social Security Number Birthplece (State or Foreign Country) **X**(**X**) M 2□ F Sep. 28, 1934 Maryland 219-32-5953 Usuel Residence of Deced 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes X X No Reisterstown MD Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street end Number U.S.A. 21136 238 Tidyman Rd. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 14 Bace - American Indian. 11 Marital Status Black, White, etc. 1 ☐ Yes XXNo If Yes, Give Year or Dates: 1 ☐ Never Merried 2 ☐ Married 1 ☐ Yes XX No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Johns Hopkins Elementary/Secondary (0-12) College (1-4or 5+) A.P.L. Machinist 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Matthew J. McCormick Evelyn Ruby 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 238 Tidyman Rd. Reisterstown, MD 21136 Betty W. McCormick / Spouse 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial XXCremetion 3 ☐ Removal from State 5 ☐ Other (Specify) Metro Crematory Inc. 11-22-04 Baltimore, MD 4 Donation 21. Signature of Fungral Solvice Licenses 22. Name and Address of Facility Eckhardt Funeral Chapel P.A. 11605 Reisterstown Rd. Owings Mills, MD21117 h?

Physician /Medical Examiner

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To the Hospital within 24 hours e To the Funerel C

Physician

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Funeral Director

Completed by

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filed within 72 hours efter death with the Maryland Hygiene.

Wher then "naturel", or Herre 23e or 28e-f show

Baltimore, Maryland 21215-0036

Item 27 is marked other than "naturel", or items 23e or 28e-f ehos other trsumstic event, the Madical Examinar must be notified at

parmit. Peges 1 and 2 should be filad Dapartmant of Haalth and Mantal Hygi Important: if Item 27 Is marked other any injury or other trsumatic event, I

Certification: To Be Completed by Physician/Medical Examiner

edical

Hospital or Attending Physicien: The lew raquires that the death certificate be axecuted

Division of Vital Records, P.O. Box 68760,

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	23a. Part1. Enter the disease, or com shock, or heart failure. List only	nplications that caused the deeth. Do not one cause on each line.	enter the mo	ode of dying, such as cardia	c or respiratory arrest,	Approximate Interval Between Onset and Death
	Immediate Cause (Final disease or condition resulting in death)	a. ATHEROSCUEROTO Due to (or as e con			LAR DISEAS	Ē
	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury	b Due to (or as a con	sequence of	·):		
	Cause (Disease or Injury that initiated events resulting in death) Last	Due to (or as e cond.	sequence of):		
,	Part II. Other significant conditions of	contributing to death but not resulting in th	e underlying	cause given in Part I.	23b. Did tobacco use cor 1 ☐ Yes 2 ☐ No	ntribute to the cause of death
					24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
	25. Was case referred to medical			26. Plece of De	1 ☐ Yes 2 No	1 □ Yes 2/2 No
	examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ Inpatient 2 ER/Outpa	itient 3□ E	Other:	Home 5 ☐ Residence 6 ☐ Oth	er (Specify)
	27. Manner of Deeth 1 Naturel 5 Pending 2 Accident investigation	28a. Dete of Injury (Month, Dey Year) 28b. Tim- Injur		28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how injury occurr	
	3 ☐ Suicide 6 ☐ Could not be determined		street, facto	ory, office	28f. Location (Street and Numb City or Town, Stete)	er or Rural Route Number,

State Registrar

completaly

31. Date filed (Month, Dey, Year)

(Check only

29b. Signature end title

29a. Certifier

MILERACI

32. Registrar's Signature

OUD COURT

5401

30. Name and eddress of person who completed cause of death (Item 23e) (Type, Print)

2004

Certifying Physician: To the best of my knowledge, death occurred at the time, date end plece, and due to the cause(s) and manner as stated.

Medical Examiner: On the Dasis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated.

29c. License number

29d. Date signed (Month, Dey, Year)

2204

21133

ORIGINAL

DHMH 16 Rev 6/95

Nicholas Zahirsky Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 04-07395 1- State Registrar 1&Unpend Trem 23a, 27-28a Per ment of Health and Mental Hygiene Certificate of Death Marsalek MAN 36938 2. Date of Death 3. Time of Death 1 Decedent's Name (First, Middle, Last) Month **Physician** arsalek 17, November 2004 0538 A M icholas /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Union Memorail Hospital Baltimore If Under 24 Hrs. Hours Min. Date of Birth (Month, Day, Year) 7-30-7 9. Birthplace (State or Foreign Country) MARYLAW If Under 1 Year 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Days 10 M 2□F Months Yrs. 26 216-98-7283 Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show 1 Yes 2 No other traumatic event, the Modical Examiner must be notified Director HALTI MORE 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ŏ or Items 23a 2/21 1045 death Funeral 12. Was Decedent/Ever in U.S. Armed Forces Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 Never Married 2 Married 1 Yes 2 No Baltimore, Maryland 21215-0036 Specify: Specify: White by 3 Widowed 4 Divorced Year or Dates: "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 2 should be filed within and Mental Hygiene. Elementary/Secondary (0-12) College (1/4or 5+) 12+ 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ennis WNR SAMES ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 19a. Informant's Name/Relationship (Type, Print) Marsale. PALMORE MD 31211 KOLONO HEIG it of Health 1045 20b. Place of Disposition (Name of cemetery, cremajory or other place)

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EVANS FUNCTION CHARE! Date 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State permit. Page Department Important: If any injury or 11/18/04 * 4 □ Donation 5 □ Other (Specify) 21. Signature of F neral Service Licensee Timonium MD 21083 22. Name and Address of Facility 2325 YOUR RD POACEFUL ALTERNATIVES FUNGRAL & CROMATIONOR Em 23a. Part1. Enter the disease, or complications that dused the death, shock, or heart failure. List only one course on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Multiple Injuries /Medical Due to (or as a consequence of). **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine burial-transit and that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the burial Box 68760 certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) P.0. the detached 9 Unknown 9 Unknown Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ director, page 2 should be 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ✓ Yes 2 □ No 24a. Was an autopsy performed 2□ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 1X Yes 2 🗌 No 5 Residence 6 Other (Specify this 28a. Date of Injury Found h. Day Year) 11-17-2004 28b Time of 28d. Describe how injury occurred unk 27. Manner of Death 28c. Injury at Work? Certification; To the Hospitel or Attanding Found at 5 Pending investigation 1 Natural after death. 1 ☐ Yes 2 No 2 Accident 6X Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) 33rd and Remington Ave., Baltimore City, Maryland determined 4 THomicide Found under a bridge within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

**EMMedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certified O.C.M.E. November 17, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201

State

Registrar

31. Date filed (Month, Day, Year)

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gistrar's Signatu

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		-	For State Ragistrar		State of	Marylan		artmen ertificat			and M	lental Hyg	jiene ag. N	nnı	36939
	Physici	an	1. Decedent's Name (First, Midd	lle, Las								2. Date of Dea Month	Day	Year	3. Time of Death
	/Medic	al -	4a. Facility Name (If not institution	on divo		Harlan	Woor		Town or	Location o	of Death	NOKHBER	-	2009 County of Death	J DI P.M
	Examin	er	4a. Pacility Name (ii not institute					4b. Ony,	1000, 01	Looption		imore			timore
	Funeral		5. Social Security Number	6. Se		7. Age (In yrs.	last birthday	/) If Under	1 Year Days	If Under Hours		8. Date of Birth	Year)		place (State or Foreign untry)
	Director		213.86.7723	11	M 2 F	42	2 Yrs.	MOHUTS	Days	riours	19111.	June 14,			California
	and w		Usual Residence of Decedent 10a. State 10b. Count	ν		10c. Cit	y, Town or I	ocation				ouno 71,	1002		10d. Inside City Limits
	Maryli f sho	ō		D-14	:				,	Arbutus					1 ☐ Yes 2 ☐ No
	r 28a	Director	Maryland 10e. Street and Number	Bail	imore			10f. Zip		<u> </u>			0g. Citize	en of What Cou	untry?
	72 hours after death with the Maryland natural', or Items 23a or 28a-f show Josal Examilier must be notified at	aiD	4307 Highview Ave	enue						212	27			U.S	.A.
	r deal	Funerai	11. Marital Status		Armed For		.S. 13	. Was Dece If Yes, spe	dent of Hi cify Cuba	ispanic Ori In, Mexicar	gin? (Sp.	ecify Yes or No- Rican, etc.)	14	 Race - Amer Black, White 	
36	s afte	by Fu	1 ☐ Never Married 2 ☐ Ma 3 ☐ Widowed 4 ☐ Divorce		1 ☐ Yes If Yes, Giv Year or Da	2 No e X		1 🗆 Yes	2 No	Specify:			5	Specify:	White
21215-0036	n 72 hours "natural", edical Ex		15. Decede					edent's Usu					16b. Kind	d of Business/li	
215	c * 3	Completed	(Specify only high Elementary/Secondary (0-12)	est grad	de completed) College (1	-4or 5+)	(Giv life.	DO NOT u	nrk done d se retired	during mos i)	t of work	ing		elec	trical
21		moC			4				ele	ctrician					
	be filed ntal Hygic of other event, I	Be (17. Father's Name (First, Middle	, Last)						18. Mothe	r's Name	e (First, Middle,	Maiden S	Sumame)	
Maryland	should be and Mental marked c umatic eve	၉			bster Moo	re	10h Ma	line Addron	/Ctmat	and Number	or Our	A al Route Numbe	my Mi		in Code)
Mai	12 7 is tra		19a. Informant's Name/Relation	isnip (<i>i</i>											
	1 an Heal em 2 ther	1	Mr. Richard J. M 20a. Method of Disposition	oore	Br	other 20b. F	Place of Disi	position (Na.	me of			Glen Burnie Date		ation - City or T	
OL	0 = =		1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (State		ematory`or (1	11/	19/2004		Baltimo	ore MD
Baltimore,	그 문문을 .	li	21 Ignal re of Funeral Service				Bay	view Cra 22. Name a	emater nd Addres	s of Facilit		10/2001		Dakimo	iio, ivib
Ö	Deparent Impo		23a Part1. Enter the disease,	1	lel _	MODS	25	S	lack F	uneral	Home	, P.A.	City N	MD 24042	
	Pnysician /Medical Examiner	ner	233 Part1. Enter the disease, shock, or heart failure. List mmediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause, (Disease or injury	or comp	aDue to (has a conseq	wence of):	the mod	all	g, such as	M	I Ulete	est,		Approximate Interval Between Onset and Death
Box 68760,	death certificate be executed e attending physician and of for use as the burial-transit	Physician/Medical Examine	Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	l	d23c. If yes, out	irth 2 🗆 Feta	ancy	Ectopic p		iln	_		23	3d. Date of delin	very Day Year
0.	t the dea by the a tached f	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown		4∐Pregn 9☐Unkno	ant at time of d	leath 5	Other (s	оеспу)						
<u>α</u>	es tha gned be de	by	Part II. Dther significant condi	tions o	ontributing to de	eath but not res	ulting in the	underlying	cause giv	en in Part I	•		bacco us		the cause of death?
I Records,		Completed					-					24a. Was a autop perfor 1 Tyes	sy .	death?	topsy findings available completion of cause of
Vital	ician: Th certificate rector, pag	Be	25. Was case referred to medic examiner?	al	Hospital:				Oth	or		h (Check only or			
of	ding Ph h. After th funeral	tion: To	1 ☐ Yes 2 ☐ No 27. Manner of Death 1 ☐ Natural 5 ☐ Pend 2 ☐ Accident invest	ling tigation	28a. Date (Mont		ER/Outpati 28b. Time Injury		28c. Injur Wor	4 111		ome 5 Resid 28d. Describe h		Other (Spec	ify)
Division	ospital or Attandi hours after death uneral Diractor: A ly filled in by the fo	Certification:	3 ☐ Suicide 6 ☐ Coul	d not be mined	289. Place	of Injury - At h	ome, farm, : fy)	street, factor	y, office			28f. Location (S City or Tow		Number or Ru	ral Route Number,
	To the Hospital or Attani within 24 hours after deat To the Funeral Director: completely filled in by the	edical			niner: On the ba							and due to the d red at the time, d	late and p	place, and due	to the cause(s)
	To the To the Comp	M	29b. Signature and title of cert	ier	1111	0		29	c. Licens	e number				signed (Month	
			44	uees					100	147	1		11	1-19-0	7
1	10		MIGUEL A.	HER	completed caus	4D. 4	13 0	e, Print)	اه، ۲ لز	eal	th A	WE.	أسلاخ	TIMORE,	MD 21228
	Sta Regist	ate rar	31. Date filed (Month, Day, Yea			egistrar's Signa	ature &	80	als						

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Miller-Brinkley Betty Jane November 18,2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Manor Care Rossville Rossville Baltimore Co. If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Days Hours Min. 1 □ M 2√2 F Director Yrs 214-30-4856 71 June 3,1933 Marvland Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28e-f shov the Medical Executrer must be notified at Director 1 Yes 2 No Maryland Baltimore Middle River 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 or items 23e 3212 Genita Lane death 21220 Funeral United States 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 72 hours after 1 ☐ Yes 2 🙀 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No þ Specify: 3 Widowed 4 Divorced 'naturel', White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) d 2 should be filed within 7; h and Mental Hygiene. 7 Is marked other then "n: Elementary/Secondary (0-12) College (1-4or 5+) Manufacturing 9 Years Glass Manufacturing treumatic event. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ukn. Roland McQuay Annabelle 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 sh Department of Health and Importent: If item 27 Is meny injury or other treum QDGE. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Robert L. Brinkley/Husband 3212 Genita Lane Middle River, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Durial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 11/22/2004 Oak Lawn Cemetery baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, 7922 Wise Ave. Dundalk, Maryland 23a. Party Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, snock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** DEMENTIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or impury that initiated events Examiner Due to (or as a consequence of): g physician and as the burial-transit The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical esn IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ō in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐ Pregnant at time of death 5 Other (specify) P.O. the 9 Unknown 9 Unknown ģ signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2X No 1 Yes 2 No 1 ☐ Yes Hospitel or Attending Physicien: director, 25. Was case referred to medical 26. Place of Death | Check only one) examiner? 1 Yes 2 No Other: 4 S Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending after death. Director: A investigation 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 | Homicide 24 hours a 1 Critifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Nov, 19 200 p 30. Name and addres person who completed cause of death (Item 23a) (Type, Print) STE 200, BALT MD 21237. H. DDIE, RD MD 9106 PHILADELPHIA 32. Registray's Signature State Registrar

MAKELLI, Albert

	Registrar				Certificate of	Death			2004	3694
cian		me (First, Middle, L					2. Date of De Month	ath Day		3. Time of Deat
lical iner	4a. Facility Name	(If not institution, a	Albert Leon	nard Mare		K Location of Death	11	40	County of Deat	7
iei	FRANK	,	11	the Cen	. 10	DECARIE		40.	Buthm	
	5. Social Security	Number 6.	Sex 7. Ag 1⊠M 2□F	e (In yrs. last birth	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da	th ly, Year)	9. Birtl	hplace (State or Fore untry) Tyland
	214-03-4 Usual Residence		123 111 2 2 1	84 Y	rs.		Feb. 1	2, 1	920 ^{Ma}	ryland
	10a. State	10b. County		10c. City, Town	or Location					10d. Inside City Lim
Director	Maryland		altimore			Dundalk				1 ☐ Yes 2 🖰
		_{lumber} Berkshire	n Dona		10f. Zip Code				en of What Co nited S	-
Funeral	11. Marital Status		12. Was Decedent	Ever in U.S.	13. Was Decedent of H If Yes, specify Cuba	21224 lispanic Origin? (Sp	ecify Yes or No		4. Race - Amer	
Fui	1 Never Ma	rried 2 Married	Armed Forces? 15€¥Yes 2 ☐ 1 If Yes, Give	40	If Yes, specify Cuba	an, Mexican, Puerto Specify:	Rican, etc.)		Black, White	e, etc.
ed by	3 🗆 Widowed	4 Divorced	Year or Dates:	WWII						White
Completed	(Sp	15. Decedent's E	rade completed)	(Decedent's Usual Occup Give kind of work done life. DO NOT use retired	ation during most of work d)	ing	16b. Kin	d of Business/I	ndustry
Com	Elementary/Sec 8Years		College (1-4or 5	1+)	Boat Builde			Owe	ens Yacl	ht Co.
Be	17. Father's Name	e (First, Middle, Las				18. Mother's Name		Maiden S	Sumame)	
2		il Marecki Name/Relationship	the will consider	40.		Mary La				
		,	recki, Jr.	753	Mailing Address (Street : 8 Berkshire	and Number or Hur. e Road D	a <i>l Route Numbe</i> unda1k ,	er, City or Marz	Town, State, Z 71and	ip Code) 21224
	20a. Method of D			20b. Place of D	Disposition (Name of crematory or other place	201	Date	20c. Loc	ation - City or 1	Town, State
		2X Cremation 3 [5 Other (Spec	□Removal from State		p Service (177/	16/2004	Tov	vson, Ma	aryland
	21. Signiture of	eral Service Lice	nsee	/	22, Name and Addres Duda-Ruch	ss of Facility ral	Home of	f Dur	ndalk,	Inc.
		well !	gram/		7922 Wise					21222
	23a. Part I. Enter	the disease, or con								
1			y one cause on each lin	- 0-	t enter the mode of dyin					Approximate Interval Between Onset and Death
	shock, or he Immediate Cause disease or condit resulting in death	e (Final ion	a. CARD	10 Res	DIRATORY					Interval Between
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7	pur *		Usual Residence of Decedent 10a. State 10b. County		10c. Cit	y, Town or L	ocation						10d. Inside City Limits
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	eath v	erai	11. Marital Status	12. Was Decedent	Ever in U	.S. 13.	Was Dece	edent of H	ispanic Origin? (St	pecify Yes or I	No-	14. Race - Am	erican Indian,
036	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other then "netural", or Items 23e or 28e-f show other treumatic event, the Medical Expoliteric ust be notified at	Completed by Funeral Director	1 ☑ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates:					ispanic Origin? (Sp in, Mexican, Puerto Specify:	Rican, etc.)		Black, Whi	
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ii o	Page ment o ent: If ury or		1 ☐ Burial 2 ☐ remation 3 ☐ `4 ☐ Donation 5 ☐ Other (Spec						orp Nov.1	5,2004	To	wson, Ma	aryland
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			· Carol A	allann	d			O.C	.M.E.		Nov	rember 1	3, 2004
_	(6)		30. Name and address of person who	md				l Pen	n Street,	Balti	more	, Maryl	and 21201
	Sta Registr		31. Date filed (Month, Day, Year)	2004 32. Registr	ar's Signa	ature	9	Spa.	6/				

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) LINDSEY MAJOR MORRIS NOVEMBER 10 2004 8:55 AM **Physician** /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner MONTGOMERY **BETHESDA** OF HEALTH NATIONAL INSTITUTES If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | (Manth, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🗹 F Director 529-47-2344 124/80 UTAH Usual Residence of Decedent death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits ital Hygiene. 5d other than "natural", or items 23s or 28a-f show event, the Nedical Exercit par must be redified at 10b. County 1 XYes 2 No Director SALT LAKE CITY SALT LAKE UTAH 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code UNITED STATES 3731 S 2140 E 84109 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 14. Race - American Indian Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status filed within 72 hours after 1 ☑ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify δ 3 Widowed 4 Divorced WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) STUDENT 3 **EDUCATION** 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 27 is marked of traumatic ever ပ BRADLEY MAJOR MORRIS STACY MORGAN von ELM 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) BRADLEY MAJOR MORRIS/ FATHER 3731 S 2140 E SALT LAKE CITY, UTAH 84109 20b. Place of Disposition (Name of competery, crematory or other place)
SALT LAKE
CITY CEMETERY Date 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages Department of Important: If it any injury or o 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State NOVEMBER 19, 2004 `4 ☐ Donation 5 ☐ Other (Specify) SALT LAKE CITY, UTAH 22 Name and Address of Facility ROBERT A. PUMPHREY FUNERAL HOME/BETHESDA-CHEVY CHASE, INC. 7557 WISCONSIN AVENUE BETHESDA, MARYLAND 20814-3501 21. Signature of Fune al Service Licenses 3501 WISCONSIN AVENUE M00335 23a. Part1. Enter the disease, or examplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 7 mos **Physician** Metastatic melanoma /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine Hospital or Attending Physician: The law requires that the death certificate be executed the attending physician and hed for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown signed by to Part II. Dther significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown page 2 should peen 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☑ No certificate has autopsy performed? 1 Yes 2 No neral Director: After this certific filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: Certification: To 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 ☐ Accident 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 \ Homicide 24 hours a 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only within 2 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D0060903 10/04 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 CENTER DRIVE, BETHESDA, Kimberl MARYLAND 20892 ecik MD 31. Date filed (Month, Day, Year) 32. Regis r's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

		_	1 - For State Registrar	State of Ma	ryland			of Health of Deat		dental Hy	giene Reg. No	UUU	36944
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.O. Box 6	the death certific y the attending p iched for use as i	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal	death 3	Ectopic pre					te of deliver	y Day Year
rds, P	es the	by	Part II. Other significant conditions co	ntributing to death bu	ut not resu	lting in the un	nderlying cau	use given in F	Part I.		_		a cause of death? bly 4 Munknown
l Rec	The law ate has b page 2 st	Completed								24a. Was a autops perform	y ned?	prior to com death?	sy findings available pletion of cause of
/ita	ilcian: T certificat rector, pa	Be (25. Was case referred to medical examiner?	11						(Check only on	8)		
of	ding Phys h. After this funeral di	tion; To	1 ☐ Yes 2 ☑ No 27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	Hospital: 1 ☐ Inpatie 28a. Date of Injur (Month, Day	ry :	R/Outpatient 28b. Time of Injury		Other: 4[c. Injury at Work? 1 ☐ Yes	2	ne 🦖 Reside 8d. Describe ho	nce 6 □Oth w injury occur	er <i>(Specify)</i> red	
5	af or Attending s after death. I Director: After d in by the fune	Sertification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Inju- building, etc	ury - At hon c. (Specify)	me, farm, stre				8f. Location (St. City or Town	reet and Numb I, State)	er or Rural	Route Number,
	To the Hospital or At within 24 hours after or To the Funeral Direct completely filled in by	Medical C	29a. Certifier 1 Certifying Phy (Check only one) 1 Medicel Exem	sicien: To the best of iner: On the basis of and manner sta	examination	rledge, death on and/or inv	occurred at estigation, in	the time, dat n my opinion,	te and place, ar death occurre	nd due to the ca d at the time, da	use(s) and ma ate and place,	anner as sta and due to t	ted. the cause(s)
	To the within 2. To the complete	Ž	29b. Signature and title of certifier	1 1			29c.	License numi		29	d. Date signe		
	NA		Con	6/4	-0	щ		D560	65		Nov	ember	12, 2004
4	71"		30. Name and address of person who Carlos E. Picon					O	horre O	and MT	200	15	
	Sta	te	31. Date filed (Month, Day, Year)	32. Registra		* 0 *			nevy Ch	iase, ML	208	1)	
	Registr		NOV 2 0 2004	Sancia	. ,	1 Sy	o actor	A. Commercial Commerci					

State of Maryland / Department of Health and Mental Hygiene 0 0 4 36946 Reg. No. Certificate of Death 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) Day Month **Physician** Rosalie Celeste Northup 12:30рм 19,2004 November /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner n/a Baltimore 6601 N. Charles St. Gilchrest 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number **Funeral** Months 1 □ M 2 🖫 F 78 219-10-6973 4-30-1926 Maryland Director Usual Residence of Decedent 10c. City, Town or Location Dundalk 10d. Inside City Limits 10a, State 10b. Counts ral', or Itams 23a or 28a-f shov Exeminer must be notified at Baltimore MD 1 ☐ Yes 2X No Direct 10f. Zip Code 21222 10g. Citizen of What Country? 10e. Street and Number 2902 Dunmore Rd. USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: þ 3 Widowed 4 Divorced "natural', Completed th and Mental Hygiene.
7 Is marked othar than "natur traumatic event, II's Maxical. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Dept. of Army Elementary/Secondary (0-12) College (1-4or 5+) Editor US Government 12th 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Maud Simpson John Blankner 19a. Informant's Name/Relationship (Type, Print) daughter9b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2282 Druid Park Dr. Baltimore, MD 21211 f Health item 27 I Bonnie Northup 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date permit. Pages 1
Department of H
Important: If ite
any injury or ot 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) 11/20/04 Baltimore, MD Greenmount 22. Name and Address of Facility Joseph N. Zannino Jr. FH 21. Signature of Funeral Service Licensee 263 S. Conkling St., Baltimore, MD 21224 Maria anneve 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Lief only one cause on each line. Approximate Interval Between Onset and Death Lung Immediate Cause (Final ConceR months Physician disease or condition resulting in death) /Medical Due to (or as a consequent of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Due to (or as a consequence of): P.O. Box 68760, Physiclan/Medlcal IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 9☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records. þ 17 Yes 2 No 3 Probably 4 Unknown structive Lung disease Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Hospital or Attanding 5 Pending investigation 1 Natural 2 Accident 1 ☐ Yes 2 ☐ No 4 hours after death. 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 150 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical (Check only one) within 2 29d. Date signed (Month, Day, Year) 29c. License number November 19, 2004 und who completed cause of death (Item 23a) (Type, Print) Ile St. Bulto. Md 2120% BINC 6701 32. Registrar's Signature 31. Date filed (Month, State 2 Registrar DHMH 17 Rev 1/2001

ORIGINAL

			4	artment of Health and Mental Hygi	ene .N2004 36947
	Physici	an	1. Decedent's Name (First, Middle, Last) Julieann Marie Neenan	2. Date of Death Month	Day Year 3. Time of Death
	/Media		4a. Facility Name (If not institution, give street and number)	November 4b. City, Town, or Location of Death	
	Examir	ıer	504 Eastview Terrace Apt. 4	Abingdon	4c. County of Death Harford
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday,	If Under 1 Year If Under 24 Hrs. 8. Date of Birth	Birtholace (State or Foreign
	Director		216-36-9250 10 M 2025 64 Yrs.	Months Days Hours Min. (Month, Day, 8-24-1)	940 BALTO MD
	land		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or L	ocation	10d. Inside City Limits
	er death with the Marylan Itams 23a or 28a-f show neth ust be multiled at	to	MD HARFORD ABI	NGDON	1 Tyes 2 Titho
	n 188	Irec	10e. Street and Number	10f. Zip Code 10	g. Citizen of What Country?
	23a c	Funeral Director	604 EASTVIEW TERRACE \$4	21009	USA
	ar dea	nuel	11. Marital Status 12. Was Decedent Ever in U.S. 13. Armed Forces?	Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
36	within 72 hours efter death with the Maryland ene. then "natural", or Itams 23s or 28s-f show the Mcdical Experient in that be incitified at	by F	1 □ Never Married 2 □ Married 1 □ Yes 2 ☑ No If Yes, Give Year or Dates:	1 ☐ Yes 2 ♣No Specify:	Specify: WHITE
215-0036	"natural", or	ted	15. Decedent's Education 16a. Dece	edent's Usual Occupation	6b. Kind of Business/Industry
215	within 7 ene. than "r	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	a kind of work done during most of working DO NOT use retired)	Day Arest
121	filed w Hygier sthar th		17. Father's Name (First, Middle, Last)	2011.7	BEIL ATLANITIC
Maryland	d la la la la la la la la la la la la la	To Be	Edward WRRCZYNSKI	18. Mother's Name (First, Middle, Mi	
ary	2 should and Men Is marke aumatic	F		ing Address (Street and Number or Rural Route Number,	
	s 1 and 2 s if Health ar itam 27 ls other trau		EdWARD NEENAN 100	ARBUTUS Rd. JOPPA, M	10 21085
altimore,				matory or other place)	Oc. Location - City or Town, State
ij			'4 □Donation 5 □ Other (Specify) ☐ GARR150	N FOREST 11/29/2004 8	WINGS MILLS, MD
Bal	permit. Pa Departmer Important any injury			2. Name and Address of Facility JOSEPH N. 263 S. CONKLING ST. E	
			23a. Part1 Enter the disease, or conplications that caused the death. Do not en shock or heart failure. Listory one cause on each line.		
	Physician		Immediate Cause (Final disease or condition	1 andration	Interval Between Onset and Death
	/Medical Examiner		resulting in death) Due to (of as a consequence of):	- D	
	Lammer	<u></u>	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):	ly Visease	
	uted I Insit	Examiner	cause. Enter Underlying Cause (Disease or injury		
o,	be executed sician and burial-transit		that initiated events resulting in death) Last C. Due to (or as a consequence of):		
8760	ate hy:	dical	d		
9	leath certific attending p	_ eu ⊲	IF FEMALE: 23c. If yes, outcome of pregnancy	-	
Вох	atten atten	Physician/M	in the past 12 months?	□Ectopic pregnancy □ Other (specify)	23d. Date of delivery Month Day Year
0.	that the de led by the a detached t	hysi	1 Yes 2 No 9 Unknown		
s, P	The law requires that the death certificate has been signed by the attending lage 2 should be detached for use as	by P	Part II. Other significant conditions contributing to death but not resulting in the u	nderlying cause given in Part I. 23e. Did toba	acco use contribute to the cause of death?
Records,	w requir been si should	ted	Hypertonoun, My persyrience,	Ingestine 12 Yes	2 No 3 Probably 4 Unknown
3ec	e law has b	Completed	Heart take, Anema, COOL	Multivity 24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of death?
a			44 Alu Torrin 25. Was e referred to medical		No 1 Yes 2 No
Vital	Phyaiclan: this certific ral director,	o Be	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 EP/Outpatien	26. Place of Death Check on one Other: 4 □ Nursing Home 5 ★ Residen	ce 6 Other (Specify)
οl		n: T	27. Manner of Death 28a. Date of Injury 28b. Time of		
sior	Attendin death. ctor: Aft y the fur	catlc	2 Accident investigation	M 1 Yes 2 No	
Division	or Attencation after death Diractor:	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, sti building, etc. (Specify)	reet, factory, office 28f. Location (Stre City or Town,	et and Number or Rural Route Number, State)
_	spital		29a. Certifier 1 Certifying Physician: To the best of my knowledge, deat	h occurred at the time, date and place, and due to the cau	use(s) and manner as stated
	To the Hospital or Attending within 24 hours after death. To the Funaral Director: After completely filled in by the fune	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/or in and manner stated.	vestigation, in my opinion, death occurred at the time, date	e and place, and due to the cause(s)
	To t To t	Σ	29b. Signature and title of certifier	29c. License number 29c	d. Date signed (Month, Day, Year)
,	1		1.1. Julento, Ms.	Dairey	11-20-04
	Uſ		30. Name and address of person who completed cause of death (Item 23a) (Type, ROSERT LIBETO, MD 3508 Bank	Print) St Balto MAD 11)) ✓
	Sta	te	31. Date filed (Month, Day Year) 2 2004 32. Registrar's Signature	a l	101
	Registr	ar *	1101 6 6 6004	Sporks	

			State of Maryland /	-			ind Men	ital Hygie	ne O O O I	06010
			1 - State Registrar	Cer	tificate d	of Death		Reg.	NZ U U 4	36948
	Physicia	an	1. Decedent's Name (First, Middle, Last) CHARLES OHLHA VER						Day Year	3. Time of Death
	/Medic		4a. Facility Name (If not institution, give street and number)		4b. City. Tow	m, or Location of		vember	17 2004 4c. County of Death	1:50P M
	Examin	er	Charlestown Care Center			onsville			Baltimo	re
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last I	birthday)	If Under 1 Ye			Date of Birth		place (State or Foreign
ь	Director		090 - 05-7429	Yrs.	Months	iys Hours	Se	pate of Birth Month, Day, Ye pt. 15,	1916 New	York
	and	}	Usual Residence of Decedent 10a. State 10b. County 10c. City, To	wn or Lo	cation					10d. Inside City Limits
	Maryl f sho	jo	Maryland Baltimore	Cato	nsville	2				1 ☐ Yes 2€ No
	r 28e	rec	10e. Street and Number		10f. Zip Cod	de		10g.	Citizen of What Cou	ntry?
	23a C	Funeral Director	715 Maiden Choice Lane; CR306		2.	1228			U.S.A.	
	tems	une	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	13. V	Was Decedent f Yes, specify (of Hispanic Orig Cuban, Mexican,	gin? (Specify , Puerto Rica	Yes or No- in, etc.)	14. Race - Ameri Black, White,	
36	rs afte	by F	1 ☐ Never Married 2 ☑ Married 1 ☑ Yes 2 ☐ No If Yes, Give WW II Year or Dates:	1	1 ☐ Yes 2 🔯	No Specify:			Specify: Whi	t a
Ş	within 72 hours after death with the Maryland one. Itan "neturel", or items 23a or 28e-f show the Modicol Examiner must be notified at	ted	15. Decedent's Education 16	a. Deced	dent's Usual Oc	cupation		16b	. Kind of Business/Ir	
215	thin 7.	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	life. [NOT use re	one during most stired)	of working			
2	filed wi Hygien other th			mmer	ical Re	eal Esta			eal Estate	9
and	I be fill ntal H ed otl	Be	17. Father's Name (<i>First, Middle, Last)</i> Charles J. Ohlhaver					rst, Middle, Maid th Hopk:		
Maryland 21215-0036	2 should be filed within 72 hours after death with the Marylan and Manier Hygene. I and Manier Hygene. Is marked other than "neturel, or liems 23a or 28e-f show surrected other than "neturel," or liems 23a or 28e-f show eumatic event. If a Madical Examired must be multihad at	٦		9b. Mailin	ng Address (Str			<u>-</u>	ty or Town, State, Zij	o Code)
	nd 2 suith ar								tonsville,	
altimore,	other tre		20a. Method of Disposition 20b. Place		sition (Name o natory or other		Date		. Location - City or To	
Ē	Pages nent of t ent: If its ury or o					ematory	11-25-	-04 La	urel, Mar	y1and
Balt	permit. Pages 1 and 2 should I Department of Health and Men Importent: If Item 27 is marke any injury or other treumatic.		21. Signature of Funeral Service Licensee	— 22 W	Name and Aditzke I	ddress of Facility Funeral	Home o	of Cator	nsville, I Ville, MD	inc.
	40 F 4 0		23a. Part1. Enter the disease, or complications that caused the death. D						ville, MD	21228 Approximate
			shock, or heart failure. List only one cause on each line.		1		oardiac or res	spiratory arrest,		Interval Between Onset and Death
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687	a X e	edic	d						170	
ŏ	death certifica e attending ph d for use as th	M/ul	IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth 2 □ Fetal dea	ath 3	Ectopic pregna	ancy			23d. Date of deliv	,
Ö.		Physiclan/Med	1 Yes 2 No		Other (specif)			<u> </u>	Month	Day Year
о. О	res that the de igned by the a be detached f	Phy	9 ☐ Unknown Part II, Other significant conditions contributing to death but not resulting	a in the	adashina anya	a swas in Bort I	1	23a Did tobacc	co use contribute to t	ha cause of death?
ds,	signe d be c	d by	Falth, Other alguments contained to death but not resulting	<i>y</i> 111 ti 1 10 ti	idenying cause	givenin Faiti.		1 ☐ Yes		
Ö	w requir been si should	etec						24a. Was an		ppsy findings available
Records,	e la has je 2	Completed						autopsy performed	? prior to co	mpletion of cause of
	i cien : Th certificate rector, pag	0	25. Was case referred to medical			26. Place		1 ☐ Yes 2 æ	No 1 □ Yes	2 No
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0	Attending Physicien: sr death. ector: After this certifici by the funeral director, I		27. Manner of Death 1 ☑Natural 5 ☐ Pending (Month, Day Year) 28a. Date of Injury (Month, Day Year)	D. Time of Injury	28c.	Injury at Work?	28d.	Describe how in	njury occurred	
sio	tendii leath. tor: A the fu	catl	2 Accident Investigation			1 ☐ Yes 2 ☐ N				
Division of Vital	l or Attencafter death Director: in by the	Certification;	4 Homicide determined 28e. Place of Injury - At home, building, etc. (Specify)	farm, stre	eet, factory, off	ice	281.	City or Town, Si	t and Number or Rura tate)	ar Houte Number,
	ospital hours unerel ly filled	alC	29a Certifier 12 Certifying Physician: To the best of my knowled	ige, death	n occurred at th	ne time, date and	d place, and	due to the cause	e(s) and manner as s	tated.
	I 4 IT 0	edical	(Check only one) Check only 2 Medical Examiner: On the basis of examination and manner stated.	and/or inv	vestigation, in r	my opinion, deatl	h occurred a	t the time, date	and place, and due t	o the cause(s)
	To the within 2 To the complet	2	29b. Signature and title of certifier		29c. Lic	cense number		29d.	Date signed (Month,	Day, Year)
•	015		Denier Darkin,	mo	0	4437	7		11/17/0	74
1	DI.		29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a Den 26 h Bourlin, m.D. 7-11 Maide 31. Date filed (Month, pay Year) 31. Date filed (Month, pay Year) 32. Registrar's Signature	1) (Type, I	Print)	/	21 -	. 11.	44 D 2170	0
	Sta	te	Den een Bowlin, m.D. 711 Maide. 31. Date filed (Month Day Year) 32. Registrar's Signature	L	P	une, c	atons	VIIICIN	MI. 06 127	· 4
	Registr		NU V Z Z 2004	P	400	als/				

			1 - For State Registrar	State of Ma	aryland	d / Dep	artment of rtificate of	Health an	d Mental Hy		+ 36949
	Physicia /Medic Examin	al	1. Decedent's Name (First, Middle, L. 6.5 P. H. 4a. Facility Name (If not institution, gr. 2.3.3 5. Social Security Number 6.	ve street and number) C. G. O. W.R.Y. Sek. 7. Age		FE ast birthday	CA		CLE	Day Year Ac County of De	2004 8/3pm
	Director		212-36-4065 Usual Residence of Decedent 10a. State 10b. County	1 M 2 F	66 10c. City	Yrs.		, nouis	7727	1938	10d. Inside City Limits
	th the Mary or 28a-f sh e notified	irector	MD Baltimo 10e. Street and Number	re		(Catonsvi			10g. Citizen of What (1 Yes 2 No
020	within 72 hours after death with the Maryland ene. Than "natural", or flems 23e or 28e-f show na Medical Examinations the ricities at	Completed by Funeral Director	233 Ridgeway Rd. 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent I Armed Forces? 1 Yes 2 N If Yes, Give Year or Dates:		S. 13.			? (Specify Yes or No ueno Rican, etc.)	Canaltu	nerican Indian, nite, etc. hite
N	bermit. Pages 1 and 2 should be filed within 72 hou Department of Health and Mental Hygiene. Important; if item 27 is marked other than *natura any injury or other traumatic event, the Medical Epoce.	Completed	15. Decedent's I (Specify only highest g Elementary/Secondary (0-12)	ducation	i+)	(Give life.	edent's Usual Occi e kind of work done DO NOT use retir Homeland	e during most of ed)		16b. Kind of Busines	•
2	should be filed nd Mental Hygis marked other umatic event, the	To Be (17. Father's Name (First, Middle, Las Alfred J. O'Ferr	all	-			Elizab	Name (First, Middle, eth Cook	,	
	i 1 and 2 sho Health and tem 27 is my other traums		19a. Informant's Name/Relationship Anne E. O Ferral 20a. Method of Disposition		20b. Pl	233 ace of Disp	Ridgeway	y Rd. CA		er, City or Town, State MD 21228 20c. Location - City of	
baitimore,	permit. Pages Department of I Important: If its any injury or o		1 Burial 2 Cremation 3 4 Donation 5 Other (Spec	ify)		timor		Crem 11,	terling-A	Laurel Mashton-Schware. Catons	D ab Funeral
	Physician /Medical Examiner	ılner	23a. Part1. Enter the disease, or conshock, or heart failure. List ont timediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to trained accause. Enter Underlying Cause (Disease or injury)	a. A Due to (or as	a consequ	eRof ence of):		/	diac or respiratory and		Approximate Interval Between Oyset and Death
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P.O. BOX 00	The law requires that the death certificate be exite has been signed by the attending physicien to be 2 should be detached for use as the buria	Physician/Med	tF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1□Live birth 4□Pregnant at 9□Unknown	2 Fetal	death 3	□Ectopic pregnan □ Other (specify)	су		23d. Date of d Month	elivery Day Year
r (SD)	w requires that been signed t should be det	þ	Part II. Other significant conditions	contributing to death be	ut not resu	ilting in the i	underlying cause g	iven in Part I.	23e. Did t	obacco use contribute Yes 2 No 3 1	to the cause of death? Probably 4 Unknown
		Completed							24a. Was autor perio 1 Yes	psy prior to prmed?/ death?	autopsy findings available completion of cause of us 2 \sum No
	tending Phy leath. tor: After this the funeral d	Certification: To Be	25. Was case referred to medical examiner? 1	be on Diese of their	ry y Year)	ER/Outpatie 28b. Time (Injury	of 28c. inju	then: 4 Nursin ury at ork? Yes 2 No	28d. Describe I	dence 6 □Other (Sp how injury occurred	
	i Si te	al Certif	4 Homicide determine	building, etc	of my knov	viedge, dea	reet, factory, office	time date and o	City or Tox	cause(s) and manner	as stated
	To the Hospital or within 24 hours after To the Funerel Dir completely filled in	Medical	(Check only 2 Medical Execution) 29b. Signature and tile of certifier	miner: On the basis of and manner sta	examinati	In T	nvestigation, in my	opinion, death o	ccurred at the time,	date and place, and du	nth, Day, Year)
2	Sta	te	30. Name and address of person who are the second of the s	completed dause of d	- 39	335	Print) John	staa	12 ELL	eoff City	19,200+

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) $^{\text{Day}}$ 16, $2\overset{\text{Year}}{004}$ Physician Arno1d Charles 01sen November 9:35 AM /Medical 4a. Fecility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Wilson Health Care Center Gaithersburg Montgomery If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) July 5, 191 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Hours 92 1912 Massachusetts Director 014-12-5485 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County in than "natural", or items 23s or 28s-f show the Medical Examinan must be notified at 1 Yes 2 □ No Maryland Montgomery Gaithersburg Direct 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? 415 Russell Ave. #D-1004 20877 United States Funeral 12, Was Decedent Ever in U.S. Armed Forces? 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: WW II Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. filed within 72 hours after 1 → Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: þ White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Accountant Federal Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 should be fill ment of Health and Mental H tant: If item 27 is marked out Be Walter 01sen J. Lutey Μ. Ellis 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Roger K. Higgins / Friend 100 Quaint Acres Dr., Silver Spring, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 'Department of h Important: If ite any injury or of once. November 18, 2004 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory Beltsville, MD 21. Signature et Funeral/Service Ligensee 22. Name and Address of Facility
Rapp Funeral and Cremation Services Rapp Funeral and Cremation 933 Gist Ave., Silver Spring 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 933 Gist Ave., Silver Spring, MD 20910 Approximate Interval Between Onset and Death Immediate Cause (Final meuntned **Physician** One weik disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner attending physicien and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) ned by the a detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by sign 1 be 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Jas page certificate 1 ☐ Yes 2 1 No 1 Yes 2 🗆 No To the Hospital or Attending Physician: Be (25. Was case referred/to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 TNo 1 Inpatient Certification: To 3 DOA 2 ER/Outpatient 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury all Work? 28b. Time of 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident after deatl 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funeral C 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as steted.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number Hoberton schlips Novemberly 30. Name and address of person who completed cause of death (Item 2 a) (Type, Print) H. Robert Birschbach M.D.; 20₺ Russell Ave., Gaithersburg, MD 20877 31, Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar DHMH 17 Rev 1/2001

DUMIN 17 Nev 1/2001

ORIGINAL

Dignin ParkS one. Maryland 21215-0036

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. AMEND ITEM #8tanspoffmaccased 101040405 and of Health and Mental Hygiense 0 0 4 1 - State Amend Item 10e&20b per fh G837C117722-04 to Seath Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Diann Gertrude Parks Month 17 2004 2300 m November /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Sinai Mospital of Baltimore Baltimore
If Under 1 Year If Under 24 Hrs. 8. Date of Birth 8-09-1956 Birthplace (State or Foreign (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Months 254-06-8555 1 ☐ M 2 🕱 F Hours Director 48 Yrs Sept.8,1956 Georgia Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "netural", or items 23a or 28a-f ehov other treumatic event, the Medical Examinar must be notified at N/AMaryland Baltimore ty Yes 2 □ No Direc 10e. Street and Number of 5612 Hadden Avenue Apt. D 10f. Zip Code 10g. Citizen of What Country? 21207 USA Funera 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. be filed within 72 hours after 1 Never Married 2 Married Specify: Black 1 ☐ Yes & ☐ No Completed by Specify: 3 ☐ Widowed 4 ☑ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Canton-Harbor Hosp 10th grade <u>Certified Nurses Assistant</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Lou Octoria Mason Cleon Parks 2 19a. Informant's Name/Relationship (Type, Print)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Jacqueline Parks/ Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5612 Haddon Avenue Baltimore, Md 21207 19a. Informant's Name/Relationship (Type, Print) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages
Department of H
Importent: If ite
any injury or of Greenmount Cemetery11-24-04 1 ☐ Burial 2 ☐ **Zremation 3 ☐ Removal from State Baltimore, Maryland `4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Chatman-Harris Funeral Home 21. Signature of uneral Service Ucensee 5240 Reisterstown Rd Baltimore, Md 21215 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Pnysician Hemorrhage disease or condition resulting in death) Intracerebral /Medical Due to (or as a consequence of): Examiner Bhours uncontrolled pertension Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of): use as the burial-transit requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): attending physician P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy for Month Day 4 Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, à pe cate has been sig , page 2 should b disease 3 Probably 4 Onknown Completed Coronary 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☑ No 24a. Was an autopsy performed 2No 1 Yes director 25. Was case referred to medical 26. Place of Death (Check only one) examiner' 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospitel or Attanding 1 Natural 5 Pending after death. investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 29b. Signature and title of certifier 2 29c. License number 29d. Date signed (Month, Day, Year) Resecca Phoietrn MD November 17,2004 RESODO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar Pr. Rebécca Phaéton MD

DHMH 17 Rev 1/2001

32. Registrar's Signature

2401 West Beivedere Avenue Baltmore M.D 21215

			State of Maryland / Department of Health and Mental Hygiene 1- State of Maryland / Department of Health and Mental Hygiene Registrar AMEND ITEM #10fs19a PER FH C838*112/06/04-311
	Physicia /Medic		1. Decedent's Name (First, Middle, Last) LOUIS POLETIS 2. Date of Death Month Day Year NOVEMBER 17, 2004 6:30P M
	Examin		4a. Facility Name (If not institution, give street and number) Saint Joseph Medical Center 4b. City, Town, or Location of Death Towson 4c. County of Death Baltimore
	Funeral Director		5. Social Security Number 219-16-2587 XXM 2 F 79 Yrs. The Under 1 Year If Under 1 Year If Under 24 Hrs.
	Aaryland show	or	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD. BALTIMORE PERRY HALL 1 □ Yes ※XXNo
	with the Na or 28e-	Direct	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9601 E AMBERLEIGH LANE 21028 21128 U. S. A.
980	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Itams 23e or 28e-f show any injury or other traumatic event, I'm Medical Examment net multiped at once.	by Funeral Director	11. Marital Status 1 Never Married XX Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes, Sive 1 Yes, Sive 1 Yes, Sive 1 Yes, Specify Cuban, Mexican, Puerto Rican, etc. 14. Race - American Indian, Black, White, etc. 14. Race - American Indian, Black, White, etc. 1 Yes, Specify: WHITE
21215-0036	d within 72 ho giene. ir than "natur I'le Medical I	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 YEARS 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) PRINTER 16b. Kind of Business/Industry (River in the complete of the complet
Maryland	ould be filed Mental Hygi arked other atic event, I	To Be C	17. Father's Name (First, Middle, Last) CONSTANTINE POLETIS 18. Mother's Name (First, Middle, Maiden Sumame) PERISTERA SAMAHOPOULOS
	1 and 2 should Health and Men Iem 27 Is marke other traumatic		19a. Informant's Name/Relationship (Type, Print) HELEN T. POLETIS (WIFE) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19c. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19c. MBERLEIGH LANE, PERRY HALL, MD., 21028
Baltimore,	permit. Pages 1 a Department of Hei Important: if item any injury or othe once.		20a. Method of Disposition XX Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) ST. DEMETRIOS CH. CEM. 20c. Location - City or Town, State 11-20-2004 CUB HILL, MARYLAND
Bal	permit. Departn Imports any inju		21. Signature of Funeral Service Licensee PL S RUCK TOWSON FUNERAL HOME, INC. 1050 YORK ROAD TOWSON, MD. 21204
	Pnysician /Medical Examiner	ar.	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. CERBROVASCULAR ACCIDENT Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):
8760,	requires that the death certificate be executed even signed by the attending physician and hould be detached for use as the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): C. Due to (or as a consequence of): d.
O. Box 6	the death certific: y the attending pl iched for use as t	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 23d. Date of delivery Month Day Year 4 Pregnant at time of death 9 Unknown 9 Unknown 9 Unknown 9 Very Year
rds, P	w requires that the de been signed by the a should be detached t	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes No 3 Probably 4 Unknown
Il Records,	The law ate has b page 2 si	Completed	24a. Was an autopsy findings available prior to completion of cause of performed? 1 □ Yes 2 No
Vital	Physician: Th this certificate ral director, pag	To Be	25. Was case referred to medical examiner? 1 Yes 2 No
on of	ing Ph After th uneral	tion; 1	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 28a. D te of Injury (Month, Day Year) 28b. Time of Injury Work? M 1 Yes 2 No
Division	To the Hospital or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the fune	Certification;	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)
	ne Hospital n 24 hours a ne Funerel I	edical (29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
)	To the within to the comp	W	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D3Ø263
	$I_{(i)}$		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
	Sta Registi		31. Date filed (Month, Day, Year) 32. Registrar's Signature NOV 2 2 2004 Server & Sports
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ORIGINAL

A B	• PARI	SE	State Unpend Item 23	State of M Ba, 27, 28	laryland / Do				•	9	14 36953
	Physicia		1. Decedent's Name (First, Middle, Last) Jetta B. Parise	_			-		2. Date of De Month NOV •	ath _	3. Time of Death 4 0900 A M
	/Medic Examin		4a. Facility Name (If not institution, give si 828 NORTH EUTAW S)			Location of Deat		4c. County o	of Death n/a
	Funeral Director	Į	237-34-4403	7. A	ge (In yrs. last birth 81 y	Months	1 Year Days	If Under 24 Hrs Hours Min.	(Month, Da	th ly, Year) 11, 1923	9. Birthplace (State or Foreign Country) Maryland
Maryland	f show	tor	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town						10d. Inside City Limits X⊠Yes 2 □ No
with the	a or 28e-	i Director	MD Baltimore 10e. Street and Number		Pikesv	10f. Zip	Code			10g. Citizen of W	hat Country?
.0036 hours after death with the Maryland	jiene. r than "naturel", or items 23a or 28e-f show the Medical Examinat must be rutified at	by Funeral	1308 Greenwood Rd. 11. Marital Status 1 □ Never Married 2 □ Married 3/24 Widowed 4 □ Divorced	2. Was Decedent Armed Forces 1 ☐ Yes 2 ☐ If Yes, Give	? ŁNo		dent of His city Cubar	spanic Origin? (S n, Mexican, Puer Specify: wh	Specify Yes or No to Rican, etc.)		- American Indian, c, White, etc. white
21215-0036 od within 72 hours af	요심	Completed b	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	Year or Dates: ation completed) College (1-4or	16a. 5	Decedent's Usu Give kind of wo life. DO NOT u	rk done d	uring most of wo	rking	16b. Kind of Bus	,
ם ﷺ	othe ent,	0	12th 17. Father's Name (First, Middle, Last)		Cle	rk		18. Mother's Na	me (First, Middle	Air Li Maiden Sumame	
Maryland	nd Mental marked umatic ev	To B	Joseph Jeanminette 19a. Informant's Name/Relationship (Type		19b.	Mailing Address	(Street a		Bishop	er, City or Town, S	State, Zip Code)
re, Ma	Health a tem 27 is other tra		Steve Jeanminette- 20a. Method of Disposition	Brother	20b Place of I	Disposition (Na	ne of	T	le, Cal	ifornia 9	94526 City or Town, State
Baltimore,	Department of Health and Menta Important: If item 27 is marked any injury or other traumatic evonce.		1 ☐ Burial Ž*** Cremation 3 ☐ Re *4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License	_	Baltimo Loudo					Baltimon	re, Maryland al Home
m s	Depa Impo any ii			ange	ed the death. Do no	36 Wilk	ens .	Ave. Bal	timore,	Maryland	
	hysician /Medical		23a. Part. Enter the disease, or complic shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	Head an	line. d neck in s a consequence of	juries					Interval Between Onset and Death
760, te be executed in	sician and burial-transit	cal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or a	s a consequence of						
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D <u>E</u>	been signed b	b	Part II. Other significant conditions con	tributing to death	but not resulting in	the underlying o	ause give	en in Part I.			bute to the cause of death? 3 Probably 4 Minknown
		Completed	OF Minary of transfer and an in-						1 Yes	psy pr prmed? de 2□No 1	Vere autopsy findings available rior to completion of cause of path?
Division of Vital	death. ctor: After this y the funeral dir	Certification: To Be	27. Manner of Death 1 Natural 2 Accident 3 Suicide 2 Suicide 3 Suicide	ospital: 1 Inpat 28a. Date of In 10 24 - 1 found 28e. Place of In	04 28b. Ti	me of unk a	28c. Injury Work 1 🗀 Y	or: 4 ☐ Nursing I	28d. Describe	dence 6 10the	or or Bural Boute Number.
	within 24 hours after To the Funerel Dire completely filled in b	edical Certi	4 ☐ Homicide 29a. Certifier 1 ☐ Certifying Phys	home sician: To the bester: On the basis	of examination and				e, and due to the	cause(s) and man	
Tothe	within 2 To the comple	Med	29b. Signature and title of certifier	and manner s	nialeu.	29	O.C	number C.M.E		29d. Date signed NOV.	(Month, Day, Year) 20, 2004
			30. Name and address of person who co	mpleted case of			reet	, Baltim	ore, Mai	ryland 21	1201
	Sta Regist		31. Date filed (Month, Day, Year)	32. Regis	trar's Signature	Sort	,				

			1 - For State Registrar	State of Mary		artment of Heartificate of De		_	iene 004	36954
	Physici		1. Decedent's Name (First, Middle, Last) Ruth Em-	na Pow	ell			2. Date of Deat Month November	Day Year	
	/Medic Examin		4a. Facility Name (If not institution, give s PRESBYTERTA 5. Social Security Number 6. Sex	1 HOME O	F MD yrs. last birthday)		MD.	21204 8. Date of Birth	4c. County of Dea	m (R) rthplace (State or Foreign
	Funeral Director			M 2X F	YO Yrs.	Months Days	Hours Min.	(Month, Day,	Year)	lary lard
	a-f show	ctor	MD 10b. County Baltimo		c. City, Town or Lo	ocation VSON				10d. Inside City Limits 1 ☐ Yes 2 ☒ No
	a or 28	i Director	10e. Street and Number 400 Georgia Court			10f. Zip Code	204	1	0g. Citizen of What C	country?
336	be filed within 72 hours after death with the Maryland tal Hygiene. d other than "natural, or items 23a or 28a-1 show event, the Mediral Examine must be notified at	by Funerai		2. Was Decedent Ever Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates:	1	Was Decedent of Hispa If Yes, specify Cuban, N 1 ☐ Yes 2 ☑ No 5		cify Yes or No- lican, etc.)	14. Race - Am Black, Wh Specify:	
Maryland 21215-0036	filed within 72 hou Hygiene. Athar than "nature int, the Wedical E	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12) 12	ation completed) College (1-4or 5+)	(Give	dent's Usual Occupation kind of work done during DO NOT use retired)	ing most of workin	g	16b. Kind of Business	s/Industry
land 2	ed tal	To Be C	17. Father's Name (First, Middle, Last) Thomas Powe1	1			3. Mother's Name			
Mary	od 2 shallth and 27 is m	-	19a. Informant's Name/Relationship (Type Presbyterian Home	•		ng Address (Street and				Zip Code)
Baltimore,	Page nent o ant: If ury or		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Ro 1 ☑ Donation 5 ☐ Other (Specify)	emoval from State	ob. Place of Dispo cemetery, crea	osition (Name of matory or other place)	Da	ite 2	20c. Location - City o	r Town, State
Balt	permit. Pag Department Important: I any injury o once.		21. Signature Euneral Service License	ade, jrecj	or s	2. Name and Address of Lite Anatom altimore, M	ny Board	655 W.	Baltimore	Street
	Prrysician /Medical Examiner		23a. Part Enter the disease, or complications, or heart failure. List only on immediate Cates (Final disease or condition resulting in death)	e cause on each line.	ile De.	ner the mode of dying, s				Approximate Interval Between Onset and Death
8760,	cate be executed physician and the burial-transit	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause, enter underlying Cause, (Disease or injury that initiated events resulting in death) Last	Due to (or as a cor						
O. Box 6	the death certifi by the attending ached for use as	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown	ic. If yes, outcome of pr 1 Live birth 2 1 4 Pregnant at time 9 Unknown	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of de Month	olivery Day Year
rds, P.	quires that n signed b	by	Part II. Other significant conditions con	ributing to death but not	t resulting in the u	nderlying cause given ir	n Part I.	23e. Did tob	es 2. No 3 □ P	o the cause of death?
Vital Records,		Completed						24a. Was ar autopsy perform 1 Yes 2	y prior to ned? death?	utopsy findings available completion of cause of
Vita	Physician: The this certificate ral director, page	Be	25. Was case referred to medical examiner?	ospital:		Othor	6. Place of Death			
of	ng fter ine	ation: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	1 ☐ Inpatient 28a. Date of Injury (Month, Day Yea	2 ER/Outpatier 28b. Time o	28c. Injury at Work?			nce 6 Other (Spe w injury occurred	ecify)
Division	Diri	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - building, etc. (Sp.	At home, farm, str	eet, factory, office	28	3f. Location (Str. City or Town	reet and Number or R , State)	ural Route Number,
	To the Hospital within 24 hours a To the Funaral Completely filled	Medical C	29a. Certifier (Check only one) 1 Certifying Phys 2 Medical Examin	ician: To the best of my er: On the basis of exar and manner stated.	knowledge, death	n occurred at the time, ovestigation, in my opinion	date and place, ar on, death occurred	nd due to the ca	use(s) and manner as ite and place, and due	s stated. e to the cause(s)
	To the to the total	Σ	29b. Signature and title of certifier	Attending	Pholici	29c. License nu 370	ımber		Od. Date signed (Moni	
5			30. Name and address of person who con Kenneth M. Green	npleted cause of death	(Item 23a) (Type,	Print) les St., Su	Je 4105	B=14-	-ore, ~0	21254
	Sta Registr		31. Date filed (Month, Day, Year) NOV 2 2 700		ignature &	Sparks	,			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygien 2 1 1 4

•	3	6	9	5	5

			1 - For State Registrar	Claic of iv	Ce	rtificate of			J. No.	30333
	Dhysisi		1. Decedent's Name (First, Mid					2. Date of Death Month	Day Year	3. Time of Death
	Physici /Media		William Alan	Pau1				NOVEMBE		2:34 P.M
	Examir		4a. Facility Name (If not instituti	on, give street and number	7)		r Location of Death		4c. County of Death	
	Funeral		Perry Point 5. Social Security Number	VA Medical C	enter ge (In yrs. last birthday,		RRY POINT	8. Date of Birth	CECIL 9. Birtho	lace (State or Foreign
	Director		212-30-4504	1 @ M 2□ F	71 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, Y October	4, 1933 M	aryland
	yland		Usual Residence of Decedent 10a. State 10b. Count	ty	10c. City, Town or L	ocation			1	Od. Inside City Limits
	8e-f sl	ctor	Maryland Ceci	1	Perry Po					1 ■Yes 2 No
	3a or 2	i Dire	10e. Street and Number Building 9H A	venue D		10f. Zip Code 21902	2	1	g. Citizen of What Cour Inited Stat	•
	s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. Item 27 is marked other then "naturel" or Items 23a or 28e-f show other treumatic event, the Medical Examble must be inclified at	Funeral Director	11. Marital Status	12. Was Deceden Armed Forces	?	Was Decedent of H If Yes, specify Cuba	lispanic Origin? (Spe an, Mexican, Puerto i		14. Race - Americ Black, White,	an Indian,
920	2 should be filed within 72 hours after dea and Mental Hygiene. Is marked other then "naturel", or Items eumatic event, the Medical Examant in	þ	1 Widowed 4 □ Divorce	arried 1 Pes 2 If Yes, Give Year or Dates:	1955-1959	1 ☐ Yes 2 🗷 No	Specify:		Specify: W	hite
21215-0036	"natur	Completed		ent's Education lest grade completed)	16a. Dece	dent's Usual Occup kind of work done	eation during most of workir d)	ng 16	b. Kind of Business/Ind	dustry
212	s should be filed within and Mental Hygiene. Is marked other then sumatic event, the Ma	dwo	Elementary/Secondary (0-12)	College (1-4or 2	5+)	i Driver	<u>1)</u>		axi servic	e
	al Hyg I othe Vent,	Be C	17. Father's Name (First, Middle	a, Last)			18. Mother's Name		iden Sumame)	
Maryland	Ments Ments arked	P	Alan C. Paul				Ethel Me	ade		
lar	2 sho		19a. Informant's Name/Relation	iship (Type, Print)	19b. Maili	ng Address (Street	and Number or Rura	Route Number, C	City or Town, State, Zip	Code)
0	and sealth m 27 her t		Donna Heikkil	a/ sister					ngwood, FL	
Baltimore,	int of H		20a. Method of Disposition 1 Burial 2 □ Cremation		cemetery, cre	osition (Name of matory or other plac	ce)	ate 20	c. Location - City or To	wn, State
ij	rtmer rtent rient njury		4 □ Donation 5 □ Other (21. Signature of Funeral Service)		Hillcres	t Cemeter			Annapolis	
Ba	permit. Pages 1 and 2 sh Department of Health and Importent: If Item 27 Is m any injury or other treum once.		M Service	It Rom	· Wii	2. Name and Addre	5017		lor Fun e ra. Annapolis.	Home, Inc
			23a. Part1. Enter the disease, shock, or heart failure. Lis	or complications that cause st only one cause on each	d the death. Do not en					Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	SEP						UNKNOWN
	/Medical Examiner		resulting in death)	Due to (or as	s a consequence of):					
	Lammer	ē	Sequentially list conditions, if any, leading to immediate	b. — Due to (or as	s a consequence of):					
11	uted id ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events	6						
, 0	e exec ian an urial-tr		resulting in death) Last		s a consequence of):					
68760,	rificate be executed ng physician and as the burial-transit	Medicai		d						
9 X	n certifi anding use as		IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome	e of pregnancy				23d. Date of deliver	
Box	atte	Physician/	in the past 12 months? 1 ☐ Yes 2 ☐ No			∃Ectopic pregnancy ∃ Other <i>(specify)</i>	′			Day Year
P.0	that the de led by the detached		9 ☐ Unknown Part II. Other significant condit		but not resulting in the u	endorheina cauco any	on in Part I	23a Did tohac	cco use contribute to the	a source of death?
Vital Records,	quires tha n signed uld be det	d by	- at it. Other significant ostical	Torio commoding to death	but not resulting in the u	- Inderlying cause givi	en in Fatti.		2 □ No 3 □ Proba	VV
CO	aw requir	Completed						24a. Was an	24b. Were autop	sy findings available
M.	The ate h page	Com						autopsy performed	d? death?	pletion of cause of 2 No
/ita	ysicien: is certific director,	Be (25. Was case referred to medic examiner?				26. Place of Death	(Check only one)		
of \	Physicien: this certificatal director,	은	1 ☐ Yes 2XXVo	and the second second	ient 2 ER/Outpatier	nt 3 DOA Oth	er: 4 🛭 Nursing Hom		e 6 Other (Specify)
	ding F h. After funera	ion	27. Manner of Death 1 X Natural 5 ☐ Pend		ury ay Year) 28b. Time o Injury	Worl		8d. Describe how	injury occurred	
Division	deat deat ctor: y the	fical	3 ☐ Suicide 6 ☐ Could	tigation I not be mined 28e. Place of In	njury - At home, farm, str		Yes 2 □ No	8f. Location (Stree	at and Number or Rural	Route Number
Ö	or in Jir	Certification:	4 Homicide deter	building, e	tc. (Specify)	,,,		City or Town, S	State)	
	To the Hospital within 24 hours a To the Funerel I completely filled	edical (29a. Certifier 1 Certify (Check only one) 2 Medice	ing Physician: To the best of Examiner: On the basis of and manner si	of examination and/or in	h occurred at the tim vestigation, in my of	ne, date and place, a pinion, death occurre	nd due to the caus d at the time, date	e(s) and manner as sta and place, and due to	ated. the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certific	er		29c. License	e number	29d.	Date signed (Month, L	Pay, Year)
			S -0	Sodni		104	1014	N	OVEMBER 13	, 2004
	.1		30. Name and address of person			•				
	4		SODHI, SURIND		D., VA MARY	LAND HEAL	TH CARE S	YSTEM, PI	ERRY POINT,	MD 21902
	Sta Registr		31. Date filed (Month, Day, Year NOV	2 2 2004 b	Signature .	5 Los	wh)			

Stevensville

10f. Zip Code

	Plea	se Type or	Prin	t in Black	Inde	elible	lnk.	Ensu	ıre A	II Copies	Are L	egible.		
For State Registrar		State	of Ma					lealth : Death		Mental Hyg	iene g. No.	200	4 36	950
1. Decedent's Name	e (First, Middle	FLO	RENC	E THERES	SA R	RAWII	NISZ			2. Date of Death Month NOVEMBER		2004	3. Time of De 10:27	
4a. Facility Name (/ 220 VES	f not institution TFIELD		ımber)					Location ILLE	of Death			ounty of Death		
5. Social Security N 189-03-		6. Sex 1 ☐ M 2 ☐ F	7. Age	(In yrs. last birthe	N	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Birth (Month, Day,	Year)	Cou	iplace (State or F intry)	oreign
Usual Residence of	Decedent										1 / 1 4	T £1	ma.	
10a. State	10b. County			10c. City, Town	or Loca	tion							10d. Inside City I	imits
Maryland	Queen	Anne's		St	evei	nsvi	11e						1 Tes 2	No X

21666

10g. Citizen of What Country?

USA

Funeral Director permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28s-f show any injury or other traumatic event, Ite Medical Exerciting Instituted at ODEs. Baltimore, Maryland 21215-0036

Physician /Medical

Examiner

220 Vestfield Road

10e. Street and Number

Funeral Director

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

by Funer	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 ☑ No If Yes. Give A Year or Dates:	3. Was Decedent of If Yes, specify Cu	Hispanic Origin? (Spec iban, Mexican, Puerto R o <i>Specity</i> :	ify Yes or No- ican, etc.)	14. Race - Ame Black, Whi	
Be Completed by	15. Decedent's Edi (Specify only highest grad Elementary/Secondary (0-12)	College (1-4or 5+)	16a. Decedent's Usual Occ (Give kind of work don life. DO NOT use retii Homemake:	e during most of working red)		Kind of Business	/Industry
To Be Co	17. Father's Name (First, Middle, Last)	Frank Bistric		18. Mother's Name (First, Middle, Maide	,	
	19a. Informant's Name/Relationship (T) Jennie J. Helwig	урө, Print) (Sister)	19b. Mailing Address (Stree 8254 Spring				
	20a. Method of Disposition 1 ☐ Burial 2 🕅 Cremation 3 ☐ I 1 ☐ Donation 5 ☐ Other (Specify,	Removal from State Ba	ace of Disposition (Name of metery, crematory or other pi yview Cremato	ry, Inc. 11	te 20c. I /22/04 Ba	Location - City or 1timore	Town, State
	21. Signature of Funeral Service Licens			ress of Facility Polyniak Fu ntain Rd.,	rasadena	e, P.A. Md. 2	1122
	23a. Part1. Enter the disease, or comp shock, or heart failure. List only o Immediate Cause (Final disease or condition resulting in death)	lications that caused the death. ne cause on each line. a. Due to (or as a conseque	Do not enter the mode of dy ence of):	ring, such as cardiac or	respiratory arrest,		Approximate Interval Between Onset and Death
by Physician/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a conseque Due to (or as a conseque d.	, 				
ysician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes No 9 □ Unknown	23c. If yes, outcome of pregnan 1 Live birth 2 Fetal of 4 Pregnant at time of dea	death 3 Ectopic pregnant	су		23d. Date of del Month	ivery Day Year
ted by Pr	Part II. Other significant conditions co	ntributing to death but not result	ting in the underlying cause g	iven in Part I.	23e. Did tobacco		the cause of death?
Completed					24a. Was an autopsy performed2	death?	topsy findings available completion of cause of
o Re	25. Was case referred to medical examiner?	Hospital:	20	26. Place of Death (and the second second		
_	27. Manner of Feath Natural 5 Pending Accident investigation	Hospital: 1 ☐ Inpatient 2 ☐ E 28a. Date of Injury (Month, Day Year)	28b. Time of 28c. Injury Wo	ther: 4 Nursing Home ury at 280 ork? Yes 2 No	5 S Residence d. escribe how inju	6 ☐ Other (Speciary occurred	city)
edical Certification:	3 Suicide 6 Could not be 4 Homicide determined		ne, farm, street, factory, office		f. Location (Street a. City or Town, Stat	9)	
ledical	one)	sicien: To the best of my know ner: On the basis of examinatic and manner stated.	on and/or investigation, in my	opinion, death occurred	d due to the cause(s at the time, date an	and manner as d place, and due	stated. to the cause(s)
Σ	29b. Signature and title of certifier	orbat o	29c. Licen	7 93 8	_	ate signed (Month	n, Day, Year)

State Registrar Mayer

30, Name and address of person who completed cause of death (Item 23a) (Type, Print)

Gorbaty

quotant Roal Glec Byone and 21061

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Rog. No. Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month ⁰2004 **Physician** 18, Nov. 8:40 A M Donald C. Rice /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltimore Towson Manor Care Dulanev If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Dec. 5, Birthplace (State or Foreign Country) York 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex 1918 **Funeral** Months 1X M 2 □ F Yrs. 126-03-7737 85 Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a State item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examinar must be notified at 1 X Yes 2 ☐ No Director Baltimore Md. 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code permit. Pages 1 and 2 should be filed within 72 hours after death with il Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 2 any Injury or other traumatic event, the Mudical Examinat must be no once. 21212 5311 St. Albans Wav by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerlo Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. 11. Marital Status ☐Yes 2√☐No fYes. Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: 3√ Widowed 4 Divorced White Year or Dates Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NDT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) +2 Director of Coal Sales 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Laura Brock Rice Charles 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 5311 St. Albans Way Baltimore, Md. 21212 Donna Brown/ Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition ₩ Burial 2 Cremation 3 Removal from State 11-20-04 Dulaney Valley Mem. Timonium, Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatur of Funeral Service Ligen 22. Name and Address of Facility Ruck Towson Funeral Home, I 1050 York Rd. Towson, Md. 2

23a. Part. Enler the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ongestive Physician disease or condition resulting in death) Due to (or as a consequence of): /Medical **Examiner** repra Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed the burial-transit nonic Due to (or as a consequence of) physician P.O. Box 68760 Physician/Medical IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day jo in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) ed by the a detached f 9 Unknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. by should be 1 Yes 2 No 3 Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 certificate has autopsy perform 1 Yes 2 No 1 Yes 2 No To the Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4. Nursing Home 1 ☐ Yes 2 No ÷ 2 5 ☐ Residence 6 ☐ Other (Specify) Pils 28b. Time of 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: After 1 Natural 5 Pending investigation after death, I Director: Aff d in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after dea
To the Funeral Director 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and fitte of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) och Pavon Blud X/AO 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar DHMH 17 Rev 1/2001

ORIGINAL

			1- State of Registrar	Maryland / D	epartment of H Certificate of L	lealth and Me Death	ental Hygien Reg. N	• • •	36958
			Decedent's Name (First, Middle, Last)				2. Date of Death		3. Time of Death
	Physicia		Frances M.	Ro1	lins	1		ay Year 20.2004	10:00 a.m
	/Medic Examin		4a. Facility Name (If not institution, give street and num			Location of Death		c. County of Death	10:00 4:11
	LAGIIIII	٠.	Genesis Elder Care 24 Truck House Road		Severna	Park		Anne Arun	del Co.
T	Funeral		Social Security Number 6. Sex	7. Age (In yrs. last birth			8. Date of Birth (Month, Day, Yea	9. Birth	place (State or Foreign ntry)
	Director		213-18-0492 1DM 20F	82 Y	rs.		11-08-1922	Mary	l'ánd
П	D >		Usual Residence of Decedent 10a, State 10b. County	10c. City, Town	or Location			1.	10d. Inside City Limits
	shov	'n							1 ☐ Yes 21 No
	28a-1	Director	Maryland Anne Arundel Co. 10e. Street and Number	Severna	10f. Zip Code		100.0	itizen of What Cou	
	a or				21146			J.S.A.	
	eath	Funerai	24 Truck House Road 11. Marital Status 12. Was Dece	dent Ever in U.S.		ispanic Origin? (Spec		14. Race - Ameri	can Indian,
	ter d	Fun	Armed For 1 Never Married 2 Married 1 Yes If Yes, Giv	ces?	13. Was Decedent of Hi If Yes, specify Cuba	n, Mexican, Puerto R	ican, etc.)	Black, White,	etc.
Š	urs a	by	3 Widowed 4 Divorced If Yes, Giv Year or Da	ers:	1 ☐ Yes ŽĄ ☐ No	Specify:		Specify: Wh	ite
5	2 ho	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. I	Decedent's Usual Occup:	ation	16b.	Kind of Business/In	dustry
,	thin i	npie	Elementary/Secondary (0-12) College (1	-4or 5+)	(Give kind of work done of life. DO NDT use retired)		1	
7	ad wi	Son	12th	Boo	k Keeper		Bai		
2	d oth	Be	17. Father's Name (First, Middle, Last)				(First, Middle, Maide	n Sumame)	
<u>z</u>	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or Itema 23a or 28a-f show eumatic event, the Marcal Examiner must be neitlied at	ဥ	Charles J. Ranke			Mary (U			
<u> </u>	- d m =		19a. Informant's Name/Relationship (Type, Print)		Mailing Address (Street a				
, ,	jes 1 and 2 of Health if item 27 I		Stephen J. Rollins		5 James Roa Disposition (Name of			Location - City or To	
5	Pages 1 nent of H int: If iter iry or oth		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from 5	cemetery	r, crematory or other plac	e) !			
	t. Pa ntmen ntent:		'4 ☐ Donation 5 ☐ Other (Specify)	Loudon	Park Cemete		-2004 bal	Limore, n	aryrand
8	permit. Pages 1 an Department of Heal Importent: If item 2 any injury or other ance.		21. Signature of Funeral Service Ligensee			rk Funera	l Home, In	ic.	2111
			23a. Pp. 1. Enter the disease, or complications that shock, or heart failure. List only one cause on	the death. Do no	ot enter the mode of duin	a such as cardiac or	reeniratory arrest		Approximate
			snock, or heart failure. List only one cause on Immediate Cause (Final	ach line.		CAAR	S. Dil As a		Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	G1026	CFROTIC	CARCI	100136	WUN	1-60
	Examiner		Due to (or as a consequence o	π):		200	2476	4 GARG
		ē	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence o	rf):				
	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events						
5	exec an an	Exa	resulting in death) Last Due to (or as a consequence o	f):				
0000	uires that the death certificate be executed signed by the attending physician and dbe detached for use as the burial-transit	dical	d						
0	tiffica ng ph as th		IS SEMANG.						
Š	th cet tendir r use	Physician/M	23b. was decedent pregnant	come of pregnancy irth 2 Fetal death	3 □Ectopic pregnancy			23d. Date of deliver	ery Day Year
	e dea he att	sici	1 Yes ZANO alloko	ant at time of death	5 Other (specify)			WOTE	Day Toll
	at the	Phy	9 Unknown	eath but not consider in	the underhilder serves grow	on in Port I	23e Did tobacco	use contribute to t	he cause of death?
ń	The law requires that the death certif ate has been signed by the attending page 2 should be detached for use an	þ	Part II. Other significant conditions contributing to de	ath but not resulting in	the underlying cause givi	en m rant.		2 □ No 3 □ Prot	
cords,	w require been si should t	Completed	Jen Core ((,)				harmen and		
i i	law asb	npie					24a. Was an autopsy performed?	24b. Were auto prior to co death?	opsy findings available impletion of cause of
=	: The	Cor	<u> </u>				1□ Yes 2 N		2 □ No
<u> </u>	icien Sertifi ector	Be	25. Was case referred to medical examiner? Hospital:		Other	26. Place of Death			
5	Phys this al dir	7	1 Yes 2 No 1 1 1 27. Manner of Death 28a. Date 0	npatient 2 ER/Out	patient 3 DOA	4 A Tursing Hom	e 5 Residence		<i>y</i>)
SION	ding l	ion	1-Matural 5 ☐ Pending (Mont		ijury Worl	k? Yes 2 □ No	5d. 2000/100 1/0W 1/1	ary occurred	
2	utten deatl ctor: y the	lica	3 ☐ Suicide 6 ☐ Could not be 28e. Place	of Injury - At home, far	m, street, factory, office		3f. Location (Street a	and Number or Rura	al Route Number,
2	after after Dire	Certification;	4 Homicide determined buildin	ng, etc. (Specify)	•		City or Town, Sta	te)	
	spite nours nerel		29a. Certifier 12 Certifying Physician: To the						
	Me Ho	edical	(Check only 2 Medical Examiner: On the ba	asis of examination and ner stated.	Vor investigation, in my o	pinion, death occurre	d at the time, date a	nd place, and due to	o the cause(s)
	To the Hospitel or Attending Physicien: The law within 24 hours after death. To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2	¥	29b. Signature and title of certifier		29c. Licenso			ate signed (Month,	
	\		> ane	M	y D	2177	P NO	vons br	22, 2004 7571MUR
	A		30. Name and address of person who completed caus		Type, Print)	Cha	10 121	ST P	ALTIMAR
	,	1	SURVEY 1- MUM		ND 3061	2.1.(1.1)	2000	- ()	21225
	Sta Registi			egistrar's Signature	6 1				
	3.0		****** ** LUU4 1	July 10 - W		# \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \			

		-	For Stata Registrar	-	epartment of Health and Mental Hygiene Certificate of Death Reg. No. 2014 369	359
	Physicia	an	1. Decedent's Name (First, Middle, Last) Minnie Belle R	lobb	2. Date of Death Month Day November 21 2004 5:15a	
	/Medic Examin		4a. Facility Name (If not institution, give s Fairhaven	treet and number)	4b. City, Town, or Location of Death Sykesville 4c. County of Death Carroll	
	Funeral	1	5. Social Security Number 6. Sex	7. Age (In yrs. last birtho	aday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State Country)	or Foreign
	Director		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town o		City Limits
	Maryla a-f shor	tor	Md Carroll	Sykes		s 2 □ No
	h with the	Funeral Director	10e. Street and Number 7200 Third Ave.	A211	10f. Zip Code 10g. Citizen of What Country? USA	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Items 23a or 28a-f show any highty or other traumatic event, I'm Medical Eracing must be notified at ance.	by Funera	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	2. Wes Decedent Ever in U.S. Amed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☐ No Specify: Specify: white	
Maryland 21215-0036	vithin 72 hou ne. han "natura na Madical E	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	Decedent's Usual Occupation Give kind of work done during most of working life. DO NOT use retired) MUSICIAN MUSIC	
land 2	ild be filed v lental Hygie ked other t ilc event, IL	To Be Co	17. Father's Name (First, Middle, Last) John Edward Garre		18. Mothers Name (First, Middle, Maiden Surname) Minnie E. Burdette	
Mary	nd 2 shou lith and N 27 is mar r traumat	-	19a. Informant's Name/Relationship (Type C. Winfield Robb (s		Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) OO Third Ave. A211, Sykesville, Md 21784	
altimore,	Pages 1 a ent of Hea nt: If Item ry or othe		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ R 1 ☐ Donation 5 ☐ Other (Specify)	emoval from State cometery.	Disposition (Name of crematory or other place) nty Cremation 11-22-04 Sykesville, Md	
Balti	permit. I Departm Importa any Inju		21. Signature of Funeral Service License Page Saught Service	erbert	22. Name and Address of Facility Haight Funeral Home & Chape P.O. Box 195 Sykesville, Md 21784	<u>1</u>
			23a. Part1. Enter the disease, or complishock, or heart failure. List only on Immediate Cause (Final	e cause on each line.	ot enter the mode of dying, such as cardiac or respiratory arrest, Interval Be Onset and	tween
ſ	/Medical Examiner		disease or condition resulting in death)	Due to (or as a consequence of)	opharin jeal disphasia. recurrent as privation preumonial	
	D #	ner	if any, leading to immediate cause. Enter Underlying		heoporosis and DJD	
8760,	icate be executed physician and s the burial-transit	dical Examin	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of)	D:	
.O. Box 68	The law requires that the death certifica to have been signed by the attending phoage 2 should be detached for use as the	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown	3c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown	3 Ectopic pregnancy 5 Other (specify)	Year
<u>α</u>	wrequires that t been signed by should be deta	þ	Part II. Other significant conditions cor	ntributing to death but not resulting in t	the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of 1 \(\triangle \tria	
Division of Vital Records,		Completed			24a. Was an autopsy findings performed? 1 Yes 2 No 1 Yes 2 No	available cause of
Vita	Physician: 1 this certifical ral director, p	o Be	25. Was case referred to medical examiner?	lospital: 1 Inpatient 2 ER/Outp	26. Place of Death (Check only one) patient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)	
on of		-	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury 28b. Tir		
Divisi	Hospital or Attending 14 hours after death. Funeral Director: Afte tely filled in by the fune	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, fam building, etc. (Specify)	m, street, factory, office 28f. Location (Street and Number or Rural Route Nur City or Town, State)	nber,
	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	Medical C			death occurred at the time, date and place, and due to the cause(s) and manner as stated. Wor investigation, in my opinion, death occurred at the time, date and place, and due to the cause((s)
	To the within 2 To the complete	Me	29b. Signature and title of certifier	IK M.D.	29c. License number 29d. Date signed (Month, Day, Year)	
	Of		30. Name and address of person who co		Type, Print)	
1	St. Regist	ate rar	31. Date filed (Month, Day, Year) NOV 2 2 20	32. Registrar's Signature	& Spark	

State of Maryland / Department of Health and Mental Hygiene 0 0 L 36960 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Mildred Kice NOVIMBER 19 2004 5:10 Am /Medical 4a Facility Neme (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Keswick Home Baltimore If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number If Under 1 Year 7. Age (In yrs. last birthday) Funeral Birthplace (State or Foreign Country) 1 M 2 X Months Days 214-01-1105 88 Director October 28, 1916 Maryland Usual Residence of Deceden permit. Pages 1 end 2 should be filed within 72 hours after death with the Marylend Department of Health and Mantal Hygiene. Important: if Item 27 is marked other than "naturel", or iname 10 any injury or other trainment. 10a. State 10b Counts 10c City Town or Location 10d. Inside City Limits item 27 is marked other than "naturel", or items 23e or 28s-f show other traumatic event, the Medical Examiner must be notified at XXX Yes 2 No Funeral Director Maryland | N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 700 West 40th Street 21211 USA 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2/07No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 11 Mantal Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes aXXNo Specify White Completed by 3X Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Alumni Relations University 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Carroll Sullivan Sr Olive Eudora Turner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bernard C Rice 1518 National Road Baltimore, Maryland 21237 Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State XXBurial 2 □ Cremation 3 □ Removal from State ☐ Donetion 5 ☐ Other (Specify) New Cathedral Cemetery 11/22/04 Baltimore, Maryland 22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home Inc ignature of Funeral Service Licens 6500 York Road Baltimore, Maryland 21212 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Physician Parkinson's Immediate Cause (Final disease or condition resulting in death) /Medical DISEASE Examiner Due to (or as a consequence of by Physician/Medical Examiner the Hospital or Attending Physician. The law requires that tha death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of) Part If. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Dementia 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? VASCULAY ACCIDENT 24a. Was an autopsy performed? Completed 1 ☐ Yes 2 No 1_Yes 25No Medicai Certification: To Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 Nursing Home 5 Residence 1 ☐ Yes 2 ☐ No 6 ☐Other (Specify) eral Director: After this fillad in by the funaral di 27. Menner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Watural 1 ☐ Yes 2 ☐ No death. 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie completely (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier mo 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ba MORE Von m.D. 104 Hilar Tunbridge 31. Date filed (Month

DHMH 16 Rev 6/95

State Registrar

32. Begistrar's Signature

		٠	For State Registrar	State of	Maryland		artmen rtificate				F	leg. No.	4	36961
	Physicia	an	Decedent's Name (First, Middle, Las	∞ Marjori	• Marv	Ricke	r			2	2. Date of Dea Month	Day	Year	3. Time of Death 6:30 p. M
)	/Medic		4a. Fecility Name (If not institution, give					Town, or	Location of	Death	Novel	mber 19, 2		
	Examin	er	,	Harmony I			,			Colun	nbia			ward
F	uneral		5. Social Security Number 6. S	ex . / 7	. Age (In yrs. I		If Under Months	1 Year Days	If Under 2 Hours	4 Hrs. 8	B. Date of Birth (Month, Day	, Year)	9. Birth	place (State or Foreign
Di	irector		212-05-2212	□M 2021F	88	Yrs.					August 22	, 1916		Maryland
land	MC II	}	Usual Residence of Decedent 10a. State 10b. County		10c. City	, Town or Lo	ocation			_				10d. Inside City Limits
Mary	Helph Market	to	Maryland Ho	ward				C	olumbia					1 □Yes 2 No
th the	or 28e	lrec	10e. Street and Number				10f. Zip	Code				10g. Citizen of		•
ath wil	23a c	ra	6336 Cedar Lane Apt. #	‡ 320					2104				U.S	
-0036 hours after death with the Maryland	n'netural, or Itams 23a or 28a-f show fedicul Exandrar must be notified at	by Funeral Director	11. Marital Status 1 Never Married 2 Married	12. Was Deced Armed Ford 1 ☐ Yes 2	es* No			1		in? (Speci Puerto Ri	ify Yes or No- ican, etc.)		ck, White	ican Indian, , etc.
030 ours a	Enal.		3 Widowed 4 □ Divorced	If Yes, Give Year or Dat	es:		1 ☐ Yes	No.	Specify:			Specif	y: 	White
2 2	netn diceit	Completed	15. Decedent's Ed (Specify only highest gra	lucation de completed)		(Give	dent's Usua kind of wor	k done a	luring most	of working	,	16b. Kind of B		
within	hen e Mu	du	Elementary/Secondary (0-12)	College (1-4	for 5+)	IITE.	DO NOT us		, nemake	r			own	home
Hyojed N	d other I		17. Father's Name (First, Middle, Last)					11011			First, Middle,	Maiden Suman	ne)	
ylan ould be	20	To Be	Henry	/ Jacke							В	ernardine	MA	Known
and Me	2 5 5	-	19a. Informant's Name/Relationship (Type, Print)		19b. Maili	ng Address	(Street a	nd Number	r or Rural I	Route Numbe	r, City or Town,		
	n 27 i ar tra		Mr. Jeffrey Ricker	S	on				. Laurel		and 2070			
D - I			20a. Method of Disposition 1 Burial 2 Cremation 3	Removal from St		lace of Dispo emetery, cre	nsition (Nan matory or o	ne of ther place	e)	Dat	te	20c. Location		
Pages ment of	ury c		* 4 ☐ Donation [#] 5 ☐ Other (Specify	1)			iew Cre				2/2004	В	altimo	re, MD
Baltimore, permit. Pages 1 an	Important: any injury		21. Signature of Funeral Service Licent	Bright	. MOI ?	293	38	ack F	uneral H d Colun	lome, F	ke Ellicott	City, MD 2	21043	
	rsician ledical		23a. Part1. Enter the disease, or composition shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a	used the death ch line.	me	_	e of dying				rest,		Approximate Interval Between Onset and Death
. Box 68760, death certificate be executed	hysician and the burial-transit	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	r as a consequ									
	by the attending ph tached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		th 2 □ Fetal nt at time of de	death 3	∃Ectopic pr ∃ Other (sp						te of deliventh	very Day Year
J	signed d be de	þ	Part II. Other significant conditions of Aor Fit Value	Local			ndertying c	ause grve	n in Part I.		23e. Did to	~		the cause of death?
Vital Records, P.O eician: The law requires that the	ate has been page 2 shoul	Completed	Primes Degen	enluit	Derne	in RA					24a. Was a autops perfor	med?	Were autoprior to codeath?	opsy findings available ompletion of cause of 2 No
	certificate rector, pag	Be C	25. Was case referred to medical examiner?							of Death (Check only or			
of Vita Physician:	G 5	2	1 ☐ Yes 27 No			ER/Outpatie			4 🗆 1401	sing Home		ence 6 □Oth		ify)
	fter	lon:	27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of (Month)	Day Year)	28b. Time o Injury	f M	8c. Injury Work	at :? ∕es 2 ∐ N		id. Describe h	ow injury occur	red	
DIVISION I or Attending	the	Certification;	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place o	of Injury - At ho g, etc. (Specify	me, farm, st					If. Location (S City or Tow	treet and Numb n, State)	er or Rui	al Route Number,
Hospita 4 hours	Funerel ely filled	Medical Ce	29a. Certifier (Check only one) 2 Medical Exam	ysician: To the base and manner	is of examinat	wledge, deat ion and/or in	h occurred vestigation,	at the tim	e, date and pinion, death	place, an	d due to the c	ause(s) and ma date and place,	anner as a	stated. to the cause(s)
To th	To the Complet	Me	29b. Signature and title of cartifier	2			290	. License	number D22	856		29d. Date signe		Day, Year)
10			30. Name and address of person who	completed cause	of death (Item	23a) (Type.	Print)					juino		/ /
V			Levine, Jerry I. MD 110					Colu	ımbia, M	1D 210	44			
	Sta Registr		31. Date filed (Month, Day, Year)		gistrar's Signat		d	200	91					

			1 = For State Registrar	State of Mar	•	artment of He rtificate of D		Re	g. No. UUL	
	Physicia		Decedent's Name (First, Middle, Last) Tere	sa Coi	nstance	Rzepiennik		2. Date of Death Month Novembe	Day Year er 18, 2004	3. Time of Death 4 5:30 A M
	/Medic Examin		4a. Facility Name (If not institution, give st	reet and number)		4b. City, Town, or L			4c. County of Deat	
			Eastpoint Nursing				stpoint			more Co.
	Funeral Director		5. Social Security Number 6. Sex 1 1	м 24СУ 7. Age ((In yrs. last birthday) Yrs.	If Under 1 Year Months Days	Hours Min.	8. Date of Birth (Month, Day, July 23		thplace (State or Foreign ountry) and
			Usual Residence of Decedent 10a. State 10b. County		IOc. City, Town or Lo	reation				10d. Inside City Limits
	laryla shov	ō	Maryland Harfor		ioc. Oxy, Town of Ec		Bel Air			1 □ Yes 2 □No
	the A	Director	10e. Street and Number			10f, Zip Code		10	0g. Citizen of What Co	ountry?
	h with	al Di	14 Bonnie Avenue				21014		United Sta	ates
	r deat	Funeral	T. Walkar Glado	Was Decedent Every Armed Forces?		Was Decedent of His If Yes, specify Cuban	panic Origin? (Spe n, Mexican, Puerto I	city Yes or No- Rican, etc.)	14. Race - Ame Black, Whit	
36	permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, I'm Madical Exait at most be rediffical at ODGE.	by Fi	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		1 ☐ Yes 2 🖾 No	Specify:		Specify:	White
9	2 hou	ted	15. Decedent's Educ (Specify only highest grade	ation	16a. Dece	dent's Usual Occupat	tion uring most of worki	na	16b. Kind of Business	Industry
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22	Hygier Hygier ther th	Col	Ukn. 17. Father's Name (First, Middle, Last)	77 1	1.70		18. Mother's Name	(First, Middle, N		Jnkn.
lan	ld be i ental i ked o ic eve	То Ве		Unkn.	Fa r bo	tka				
Maryland 21215-0036	shou and M a mar	-	19a. Informant's Name/Relationship (Typ	e, Print)	19b. Maili	ng Address (Street ar	nd Number or Rura	l Route Number,	City or Town, State, 2	Zip Code)
	and 2 ealth m 27 i		David Rzepiennik	(Son)	The same of the sa	Bonnie Ave		ir, Mary	land 2101 20c. Location - City or	
Baltimore,	iges 1 if ite or oth	H	20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Re	emoval from State		osition (Name of matory or other place	!		•	
Ħ	artmer ortant injury		* 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service License	9		islaus Cem 2. Name and Address		1/22/200	04 Dundal	lk, Maryland
å	Depared Depared Important in suny in s		> Stephane	Mass	KIN -	7022 575 00	Arro Dans	M JIFF	Dundalk, 3	In c. 1222
			23a. Part1. Enter the disease, or complice shock, or heart failure. List only one	ations that caused the cause on each line	he death. Do not en	ter the mode of dying	, such as cardiac o	r respiratory arre	est,	Approximate Interval Between Onset and Death
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	/Medical Examiner			Due to (or as a	consequence of):					
	Helwin	Jer	Sequentially list conditions, if any, leading to immediate	Due to (or as a	consequence of):					
	acuted and transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Due to for so o	concernos of):					
8760,	cate be executed physician and s the burial-transit	al E	rosaming in dodairy cast	Due to (or as a	consequence of):					
687	ificate g phys as the	edical	0.							tirker
Box	death certific e attending p id for use as	an/M	23b. Was decedent pregnant	3c. If yes, outcome of 1□Live birth 2		☐Ectopic pregnancy			23d. Date of de Month	livery Day Year
.O.	0 0 2	Physician/Me	in the past 12 months? 1 □ Yes 2 ☑No 9 □ Unknown	4□Pregnant at tii 9□Unknown	me of death 5(Other (specify)				
٥.	requires that the een signed by th hould be detache	by Ph	Part II. Other significant conditions con	tributing to death but	not resulting in the t	ınderlying cause give	n in Part I.	23e. Did tob	pacco use contribute to	o the cause of death?
rds,	w requires been sign should be							1 □ Ye	es 2□No 3□Pr	robably 4-⊠Unknown
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<u>~</u>	The ate h page	Соп						perform 1 Yes 2		s 2□No
Vital	Physician: Th this certificate ral director, pag	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ◯ No	ospital:	t 2 ER/Outpatie	nt 3 DOA Othe	26. Place of Death		e) ence 6 ⊡Other <i>(Spe</i>	aciful
of		-	27. Manner of Death	1 Inpatient 28a. Date of Injury (Month, Day)	28b. Time of				ow injury occurred	Uny/
sion	Attending it death.	atio	1 Natural 5 Pending 2 Accident investigation	(1001111, 0-1)	,,		res 2 □ No			
Division	or Att	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injur- building, etc.	y · At home, farm, si (Specify)	reet, factory, office		28f. Location (St. City or Towr	reet and Number or R n, State)	ural Route Number,
_	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fo								ause(s) and manner as ate and place, and due	
	the H hin 24 the Fi	Aedical	one)	and manner state		29c. License			9d. Date signed (Mont	
\	To To	Z	29b. Signature and title of certifier	<u></u>		~	3725		11/18/	
,	/		30. Name and address of person who co.	mpleted cause of dea	ath (Item 23a) (Type	Print)			2	-1221
	5		TARIQ MAU	thoop ?	201-109	BackR	iver N	eck R	d Balh	mere
	St Regist	ate rar	31. Date filed (Month, Day, Year) NOV 2 2 2	(MOOD 2 004 32. Registrar	's Signature	Spars	ts .			

State of Maryland / Department of Health and Mental Hygiena Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 2¥vv4 3:30am м Vivian Ricketts /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Rockville, MD. Montgomery Shady Grove Hospital If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9/20/1935 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days Hours Maryland 1 M 2 TXF 69 Yrs. 217-32-2492 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mentat Hysiene important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event. The Medical Ergar instrintative by rottlied at once. 1 Yes 2 □ No Rockville MD. Montgomery Direct 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 20850 715 Crabb Avenue Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ZXNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married white Baltimore, Maryland 21215-0036 1 ☐ Yes 💹 No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Margaret Ricketts Ricketts Ernest 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 720 Crahb Ave.Rockville, MD. 20850 19a. Informant's Name/Relationship (Type, Print) 720 Crabb Ave.Rockville, MD. John Thomas Ricketts 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 XX emation 3 ☐ Removal from State 11/17/04 Beltsville, MD. CHesapeake Crematory * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 933 Gist Ave. Silver Spring, MD. 20910 23a. Fart! Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Qriset and Death Immediate Cause (Final disease or condition resulting in death) oma Physician nousi /Medical Due to (or as a consequence of): Examiner brovas aclar 646 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) Yes should be detached 9☐ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. noirnet 1 Yes 2 No 3 Probably 4 Umknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed? 2 No 1 Yes 2 NO 1 Tyes Be 25. Was case referred to predical examiner? director 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Beath 28c. Injury at Work? 28d. Describe how injury occurred Certification: After To the Hospitai or Attending 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A 2 Accident the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Thomicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only completely 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 10054068 ber 15 30. Name and address of person who completed cause of de th (Item 23a) (Type, Print) Gaithersburg tectical Drive Isabelle 8910 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

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December 19 Provided Provid			1	For State Registrar	State of Ma	ıryland		artment of H tificate of			F	leg. No.	004		964
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23. Signature of European Service Licensee 24. Name and Address of Facility JARTES A. TRANSIN SONS 7.11. 1.10. 25. Part Enter the desease, or combicilations that baused the death. Do not enter the mode of dying, such as cardac or respiratory arrest, mineral shock, or heart failure. List only one cause on each line. 25. Due to (or as a consequence of): 26. Due to (or as a consequence of): 27. Due to (or as a consequence of): 28. Due to (or as a consequence of): 29. Due to (or a	nor	m 0 .		1 Surial 2 Cremation		1-	1	1	1	11 24	04				
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			For State Registrar	State of Marylan	d / Depa	artment of the tificate of	Health and <i>Death</i>		Reg. No.		
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ဓ္ဌ	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene important: if item 27 is marked other then "neturel", or itema 23a or 28a-f show amy injury or other traumatic event, the Medical Examination and lied at Once.	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:		Was Decedent of If Yes, specify Cu 1 ☐ Yes 2 ☆ No		(Specify Yes or No arto Rican, etc.)	14. Race - Black, Specify:	American Indian, White, etc. Black	
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State of Maryland / Department of Health and Mental Hygien 👂 🛭 🗓 🗓 36966 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** November 19, 2004 5:35 pm M CHARLES H. SADOWSKI, SR. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Towson Greater Baltimore Medical Center If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Days Hours 1 🔀 M 2 🗆 F 72 1/13/1932 MARYLAND Director 215-28-5861 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County itam 27 is markad othar than "natural", or Itams 23a or 28e-f show other traumatic evant, Ine Madical Extending on ust be multified at 1 ☐ Yes 2 ☐ No Director MD BALTIMORE TOWSON 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 1628 THETFORD ROAD 21286 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 XYes 2 □ No If Yes, Give Year or Dates: KOREAN 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Specify: WHITE Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry d 2 should be filed within 7 in and Mental Hygiena.
7 Is markad othar than "r e filed within College (1-4or 5+) Elementary/Secondary (0-12) SAFETY ENGINEER PROCTOR & GAMBLE YEARS 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) ALEXANDER SADOWSKI SUSAN NELSON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If itam 27 Is any Injury or other trainonce. ELIZABETH C. SADOWSKI WIFE 1628 THETFORD ROAD TOWSON, MD 21286 20b. Place of Disposition (Name of cemetery, crematory or other p 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ₺ Burial 2 □ Cremation 3 □ Removal from State DULANEY VALLEY MEM. 11/23/2004 COCKEYSVILLE, MD 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility THE JOHNSON FUNERAL HOME, P.A. 8521 LOCH RAVEN BLVD. TOWSON, MD 23a/Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Cerebro vascular acciden 24th **Physician** /Medical Due to (or as a consequence of) Examiner Myocardia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last the attending physicien and hed for use as the burial-transit Due to (or as a consequence of Division of Vital Records, P.O. Box 68760. neumonia certificate be Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Dav in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Aftar this certificate has been signal funeral director, page 2 should be ertension 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2□ No 1 Yes Hospital or Attanding Physician:
24 hours after death.
9 Funaral Director: Aftar this certified 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 Tes 2 □ No 2 Accident 3 Suicide 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 🗌 Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medicai completely (Check only one) and manner stated. within 2. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Towson 1312 rouch TUN KHIN M 32. Registrar's Signature State

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Registrar

			For State Registrar	State of Ma	ryland /	•	rtment of H				iene	004	369	67
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	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: if Item 27 is marked other than "natural; or Items 23a or 28e-1 show appring to other traumatic avent, the Medical Examinat rutal transmitted at anone.		19a. Informant's Name/Relationship Maria McClain/gra		100		g Address (Street a Forest V			Forest			21050	
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			21. Signature of Funeral Service Licensee 22. Name and Address of Facility Mitchell—Wiedefeld Funeral Home, Inc. 6500 York Rd. Baltimore, MD 21212 23a Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Interval Between										ween	
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David P. Schmitt 04

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State of Maryland /	Departme	nt of Health and	Mental Hygiens	,
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and *	200	-	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	or Lo	cation					10	d. Inside (Dity Limits
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SiO SiO Seath.	the fu	cati	2 Accident investigat 3 Suicide 6 Could not	ho .	-iv At home for]Yes 2 □No	28f. Location	/Stroot a	and Numbe	or or Rum	l Route Nu	ımher
Division of Vital Records, le or Attending Physician: The law requires to after death.	in by	ertification;	4 Homicide determine	289. Place of I	njury - At nome, fa atc. (Specify)	arm, St	reet, factory, office		City or T	own, Sta	te)	, or muld	10010 140	,,,,,,,
Division of the Hospital or Attendithin 24 hours after death of the Lunaral Director.	filled in by the	O	On Cartifica 1 Cartifician	Physician: To the bes	t of my knowledge	a dos	th occurred at the	ime date and place	and due to th	A Causel	s) and mar	nner as et	ated	
Hos 24 ho	stely 1	edical	29a. Certifier (Check only only only)	eminer: On the basis and manners	of examination an	nd/or in	ivestigation, in my	opinion, death occur	red at the time	e, date ar	nd place, a	nd due to	the cause	(s)
To the within	completely	Me	29b. Signature and title of certifier	1			29c. Licen	se number		29d. D	ate signed	(Month,	Day, Year)	

31. Date filed (Month, Day, Year)
NOV 2 2 2004

d address of person who completed cause of death (Item 23a) (Type, Print)

A Row Lotte, MD

1 32. Registrar's Signature

111 Penn Street, Baltimore, Maryland 21201

November 16, 2004

State Registrar

O.C.M.E.

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State of Maryland / Department of Health and I	Mental Hygiene	0.0
Cartificate of Dooth	_	$\mathbf{U} \mathbf{U}$

Lucille	Schwill
04-7406	
AKC	1-

36970

KG			1 - State Registrar			Cei	rtificate of	Death		Reg. N	L U U	-4	30310
			1. Decedent's Name (First, Middle,	Last)					2. Date of		\		3. Time of Death
	Physici		Lucille Schw	ilck					Nov Nov		nber 17, 2004 2:52 PM		
	/Medio Examin		4a. Fecility Name (If not institution,	give street and num	nber)		4b. City, Town,	or Location of E	Death	4	c. County of	Death	
1	2.44		4200 Loch Raven	Boulevar	d Apt.	393	Baltimo	re					
	Funeral		5. Social Security Number	3. Sex	7. Age (<i>ln yr</i> s. <i>l</i> a:	st birthday)	If Under 1 Year Months Days	If Under 24	Hrs. 8. Date o	f Birth J. Day, Yea 23, 19	(r) 9	. Birthpl	ace (State or Foreign try)
	Director		481-12-2950	1 □ M 2 🂢 F	99	Yrs.	Monard Bayo		Oct 2	23, 19	905	Iowa	i"
	pu >		Usual Residence of Decedent 10a. State 10b. County		10c City	Town or Lo	cation					10	Od. Inside City Limits
	aryla shov	5	MD 100. County		iou. Oxy,		imore						1 Yes 2 □ No
	Pe M	ecto	10e. Street and Number				10f. Zip Code			100.0	Citizen of Wha	at Count	to/?
	with t	급	4200 Loch Rave	n Blvd #39	03		Toi. Zip code	21218	0	109.		at Oodin	
	s 23	erai	11. Marital Status		dent Ever in U.S.	13 1	Was Decedent of			r No-	USA 14. Race -	America	an Indian,
	Itam Iren	ij.	1 Never Married 2 Marrie	Armed For	ces? 2 X No		Was Decedent of if Yes, specify Cub		uerto Rican, etc	.)		White, e	etc.
21215-0036	72 hours after death with the Maryland natural', or Itams 23a or 28a-f show dical Examiner must be notified at	by Funeral Director	3 Widowed 4 Divorced	If Yes, Give Year or Da	0		1 □ Yes 2X No	Specify:			Specify:	W	hite
ò	2 hou	ted	15. Decedent's	Education		16a. Deced	dent's Usual Occu	pation	f wastele a	16b.	Kind of Busir	ness/Ind	lustry
715	within 73 ene. than "n	Completed	(Specify only highest Elementary/Secondary (0-12)	Grade completed) College (1-	-4or 5+)	life. i	kind of work done DO NOT use retire	auring most of ad)	r working				
21	filed withi Hygiene. other then	ĕ	12	0	,	te	acher				eduça	tion	n
	be filed tal Hygid d othar evant, II	Be (17. Father's Name (First, Middle, L					18. Mother's	Name (First, Mi	ddle, Maide	en Sumame)		
/lai	should be ind Mental markad o	10	William Scl	nwilck				Aı	cminda C	rawfo	rd		
Maryland	2 sho and I Is me		19a. Informant's Name/Relationshi		- 1		ng Address (Stree			,			
	rtr		Cleva Van Fle	et/niece			West Jac	kson St					
ore	ges 1 it of He if iter or oth		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation	3 □Removal from S	000	ice of Dispo netery, crer	sition (Name of natory or other pla	ice)	Date	20c.	Location - Cit	ty or To	wn, State
<u>Ē</u>	Pages ment of ant: If it ury or o		* 4 XDonation 5 ☐ Other (Sp.	ecify)				1					
Baltimore,	permit. Pages 1 a Department of Hes Important: If item any injury or otha		21. Signature of Euneral S. rvice L Ronal d S	. Wade, D	rector	Si Ba	Name and Addr tate Anat altimore	ess of Facility Comy Bo MD 2	ard 655 1201	W. Ba	altimon	re S	treet
		-	23a. Part1. Enter the disease, or o	omplications that ca	aused the death.					ory arrest,			Approximate Interval Between
			shock, or heart failure. List o	nly one cause on ea	ach line.	4	1.	0	- Die				Onset and Death
	Physician /Medical		disease or condition resulting in death)	a. Due to /	or as a conseque	ence of):	(inches	مع ندوم	the	-		-	
	Examiner			540.00	0. 40 4 0000 400								
	100	ē	Sequentially list conditions, if any, leading to immediate	b. Due to (c	or as a conseque	ence of):							
	uted d ansit	Ë	Cause (Disease or injury that initiated events	â									
oʻ	exec an an rial-tr	Exa	resulting in death) Last	Due to (d	or as a conseque	ence of):							
68760,	te be ysicia ne bu	cal		d									
99	certificate be executed ding physician and se as the burial-transit	/Medical Examiner	IF FEMALE:										
Box			23b. Was decedent pregnant		come of pregnand irth 2 Fetal d		Ectopic pregnanc	:y			23d. Date of Month		ry Day Year
	e dea he at	sici	in the past 12 months? 1 □ Yes 2 No	4☐Pregna 9☐ Unkno	ant at time of dea	ath 5□	Other (specify) _		<u>.</u>	-	WOTE		Duy . du.
P.0	law requires that the death as been signed by the atten 2 should be detached for u	Physicia	9 Unknown Part II. Other significant condition		ath but and sacret	in a la Mana		on Dod I	230	Did tabacco	a uea contribu	ite to the	e cause of death?
	res the	b	Part II. Other significant condition	is contributing to de	ath but not result	iing in trie u	ndenying cause gi	ven in rait i.		1 ☐ Yes		☐ Proba	4.
ord	requi	ted							_				
of Vital Records,	law las b	Completed								Was an autopsy	24b. We	re autop	sy findings available pletion of cause of
E	sician: The law certificate has b lirector, page 2 s	5							1 🗆 Y	es 2.00/		th? Yes	2 No
/ita	cian: ertific	Be	25. Was case referred to medical examiner?	44 3 1					Death (Check o	nly one)			,
£ \	> 0 0	2	1½∑Yes 2□No			R/Outpatier	IL SEL DON		ng Home 5 🗆 I			(Specify	at scene
	ing P	on:	27. Manner of Death 1 Natural 5 Pending		of Injury h, Day Year)	28b. Time of Injury	Wo			ribe how in	jury occurred		
sio	Attanding r death. actor: After by the fune	catl	2 Accident investiga 3 Suicide 6 Could no	ot be	71.1]Yes 2□No		on (Stroot	and Alumbas	or Burn!	Doute Number
Division	or At fter d Diraci	Certification:	4 Homicide determin	256. Place	of Injury - At noming, etc. (Specify)	ne, rarm, str	eet, factory, office		City o	r Town, Sta	ite)	or Murar	Route Number,
	urs a	ပိ	20 Continue 4 Continue	Dhusisian Tuttu	h = 1 = 1 = 1 = 1 = 1 = 1			in a data and a	alana, and due to	the course	(a) and mann	er on etc	atod.
	To the Hospital or Attanding Phwithin 24 hours after death. To the Funaral Diractor: After the completely filled in by the funeral	Medical	29a. Certifier 1 Certifying (Check only one)	Physicien: To the xeminer: On the ba and mann	sis of examination	on and/or in	vestigation, in my	opinion, death	occurred at the ti	me, date a	nd place, and	due to	the cause(s)
	To th Withir To th comp	Me	29b. Signature and title of certifier				29c. Licen	se number		29d. E	ate signed (/	Month, E	Day, Year)
			1 Thender	Il. Kin	mun		O.C.	М.Е.		Nov	ember	18,	2004
			30. Name and address of person w	no completed cause	of death (Item 2	23a) (Type,							
			THE VOORE M	King			111 Pen	n Stree	et, Balt	imore	, Mary	land	d 2
	Sta		31. Date filed (Month, Day, Year)	32. Re	egistrar's Signatu	re 4	Sport	2					
	Regist	rar	NOV 2 2	2004	Nimbers .	1	Jan de						

			For State Registrer	State of Ma	ryland		rtment of H		and Me	ntal Hy	giene	004	36971
			Registrer Decedent's Name (First, Middle, Landson Lan	ast)			inicate of L	Jeaur	2	. Date of De	ath		3. Time of Death
	Physicia		BRIAN SF	EAR					N	Month OVENES	Day 18	Year Zwo4	10:59AM
	/Medic Examin		4a. Facility Name (If not institution, gi	ve street and number)			4b. City, Town, or				4c. Co	ounty of Dea	th
			University of Marry				BALTIN						
	Funeral		, , , , , , , , , , , , , , , , , , , ,	Sex 7. Age 1 XM 2 F	(In yrs. last	t birthday) Yrs.	If Under 1 Year Months Days	If Under Hours	Min.	Date of Bir (Month, Da -30-	th y, Year)	Co	thplace (State or Foreign buntry) VYork
	Director		Usual Residence of Decedent						- 4	-30-		Mer	W TOLK
	rylanc how		10a. State 10b. County	1-	10c. City, T								10d. Inside City Limits
	Be-f e	ecto		/a	Dar	cimor	7				10.00	(1411)	12 Yes 2 No
	th with the 23a or 2 tall be n	ai Dire	10e. Street and Number 228 S. Ann S	treet			10f. Zip Code 2	21231			_	n of What Co ISA	ountry?
336	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Important: If item 27 le marked other then "naturel", or items 23a or 28e-f ehow eny injury or other treumatic event, the Medical Examiner must be notified at once.	by Funeral Director	11. Marital Status 1汉 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent E Armed Forces? 1 1 Y Yes 2 ☐ No If Yes, Give Year or Dates:		ine 13. V	Vas Decedent of Hi Yes, specify Cubar ☐ Yes 2X No	spanic Ori n, Mexican Specify:	gin? (Specit i, Puerto Ric	fy Yes or No can, etc.)		Race - Ame Black, Whit pecify:Wh	
O O	72 hor	ted	15. Decedent's 8 (Specify only highest g		1	16a. Deced	ent's Usual Occupa	ation	t of working		16b. Kind	of Business	/Industry
21215-0036	ithin 7.	Completed	Elementary/Secondary (0-12)	College (1-4or 5+		IITO. L	O NOT use retirea,)			Sou	rce (One
7	iled w Hygier ther th		17. Father's Name (First, Middle, Las	1+		Erec	ctrical			First, Middle	Maiden Su	ımame)	
/lanc	uld be f Wental H Irked of	To Be	John Spear							Farwe			
Maryland	nd 2 sho lth and 27 le ma treuma		19a. Informant's Name/Relationship Ms. Janette B				g Address (Street a E. Faye						•
ē,	s 1 ar f Hea item 3		20a. Method of Disposition	_	20b. Plac	e of Dispos	sition (Name of natory or other place	0)	Dat	е	20c. Loca	tion - City or	Town, State
E	Page nent o int: If		1 ☐ Burial 2 ② Cremation 3 4 ☐ Donation 5 ☐ Other (Spec			enmo		!	11/22	2/04	Balt:	imore	, MD
Baltimore,	permit. Departn Imports eny inju		21. Signature of Funeral Service Lice	ensee		22	Name and Addres	s of Facilit	y Jos	eph I	V. Za Ltimo	nnind re. I	Jr. FH
		-	23. Part1. Enter the disease, or conshock, or heart failure. List of	plications that caused to	the eath. I								Approximate
1	Physician		mmediate Cause (Final	one cause on each line		(0)	2/15						Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	Due to or as a		ice of):						-	6 manths
	Examiner	-	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as a	consequer	nce of):							
	cuted Id ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	c.									
60,	ate be executed hysician and the burial-transit		resulting in death) Last	Due to (or as a	consequer	nce of):							
68760,	icate l physi s the b	dical		d									
	death certificate b e attending physion of for use as the b	n/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of							230	d. Date of de	livery
P.O. Box	0 0 0	Physician/Med	in the past 12 months? 1 \(\text{Yes} \) 2 \(\text{No} \)	1 ☐ Live birth 2 4 ☐ Pregnant at t 9 ☐ Unknown	_		Ectopic pregnancy Other (specify)					Month	Day Year
	hat the	Phy	9 ☐ Unknown Part II. Other significant conditions	contributing to death but	t not resultir	ng in the ur	derlying cause give	en in Part I		23e. Did t	obacco use	contribute to	the cause of death?
Records,	The law requires that the de ate has been signed by the a bage 2 should be detached	ed by		tive Rulma		-					Yes 2□!		robably 4 Unknown
seco!	a wa	Completed								24a. Was		24b. Were au prior to death?	utopsy findings available completion of cause of
alF										1 Yes	2 No	1 Yes	2 1 No
Ζ	Physiclen: this certificatal director, I	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital: 1 Inpatien	1 2 TEB	VOutnatien	t 3 DOA Othe)C		Check only o		Other (Spe	cihi)
10	g Phy er this eral d	-	27. Manner of Death	28a. Date of Injury (Month, Day		Bb. Time of Injury	28c. Injury Work			d. Describe			City)
ion	arth. or: Aft	atio	1 ☑ ¶atural 5 ☐ Pending 2 ☐ Accident investigati	on	7 0017	Injury		Yes 2 🔲	No				
Division of Vital	To the Hospital or Attending Physiclen: within 24 hours after death. To the Funerel Director: After this certifica completely filled in by the funeral director,	Certification:	3 Suicide 6 Could not determine		ry - At home (Specify)	e, farm, stre	eet, factory, office		281	f. Location (City or To		lumber or Ri	ural Route Number,
	ospital hours unerel		29a. Certifier 1 Certifying F	Physicien: To the best of eminer: On the basis of the bas	f my knowle	edge, death	occurred at the tim	ie, date an	d place, and	d due to the	cause(s) an	id manner as	s stated.
	o the H ithin 24 o the F omplete	Medicai	one) 29b. Signature and title of certitier	and manner stat	ed.	T dillor of life	29c. License						h, Day, Year)
	. \		1 (silva	ND					1				, 2004
Î	5 X		30. Name and address of person who	completed cause of de	ath (Item 23	3a) (Type, I							-
	Sta	ite .	31. Date filed (Month, Day, Year)	32. Registra	r's Signatur	0	J., CJA		1-1				
•	Registi		NOV 2 2 2	ocompleted cause of de MD, ZZ 5	war	6	Sparks						

			Fiedse			artment of Health and		•	
			For Stete Registrer	State of Maryla		rtificate of Death		2004	36972
П		-9	Decedent's Name (First, Middle, L.)	ast)			2. Date of Death	1	3. Time of Death
	Physicia /Medic		Clarence Dennis	Smothers			NOVEMB	ER 13 Pear	4 17:30M
	Examin		4a Facility Name (If not institution, gr			4b. City, Town, or Location of Deat		4c. County of Dea	ith
°sa.				TALOFBA	WIMO	RE BACTMC	8. Date of Birth	/	the least of the second
	Funeral Director		5. Social Security Number 6. 229-54-8134	Sex, 7. Age (In y.	rs. last birthday) 59 Yrs.	Months Days Hours Min.		Year) C	thplace (State or Foreign ountry) Sqinia
Ь.			Usual Residence of Decedent				reb 10,	1943 11	gilla
	arylan show	_	10a. State 10b. County	10c.	City, Town or Lo	cation			10d. Inside City Limits 1 1 Yes 2 □ No
	he Ma	Director	MD N/A	Ва	altimore		10	g. Citizen of What C	
	death with the Maryland ma 23a or 28a-f show rmust be rediffed at	5	10e. Street and Number			10f. Zip Code 21215		nited Sta	
	death	Funeral	2434 W. Belvedere	12. Was Decedent Ever in	n U.S. 13.	Was Decedent of Hispanic Origin? (S f Yes, specify Cuban, Mexican, Puer		14. Race - Am	erican Indian,
	or Ite		1 Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 No If Yes, Give		f Yes, specify Cuban, Mexican, Puer 1 ☐ Yes 2 ☑ No Specify:	to Rican, etc.)	Black, Whi	te, etc.
3-003e	hours after tural', or Ita al Examina	d by	3 Widowed 4 Divorced	Year or Dates:		^		Specify: Blac	
ດໍ	"natı	Completed	15. Decedent's l (Specify only highest g		16a. Deced	dent's Usual Occupation kind of work done during most of wo DO NOT use retired)	rking	6b. Kind of Business Onstructio	•
7	within iene. than "	omp	Elementary/Secondary (0-12)	College (1-4or 5+)		ruction Worker		Olistideti	511
0	be filed within 72 hours after death with the Marylan de Hygiene. I shygiene. I cher than "natural", or Itema 23a or 28a-f show event, the Madical Examination and event, the Madical Examination at	Be C	17. Father's Name (First, Middle, Las	:t)			me (First, Middle, M	faiden Sumame)	
/land		10 E	John Smothers			Laura I	efitch		
Mar			19a, Informant's Name/Relationship			ng Address (Street and Number or Ri			
e S	1 and 1 ealth 1 am 27 1 her ti		Mr. Robert Smoth			Sheridan Avenue,		e, MD 2123	
ě	permit. Pages 1 and Department of Healinportant: If Item 2 any injury or other once.		1 Burial 2 Cremation 3	□ nemovar nom state			Nov 16		
Baltimor	nit. Partme ortan injury		21. Signature of Funeral Service Lice	2000	20	2. Name and Address of Facility	HORSEL CO. C.	eltsville,	, MD
n	Depar Impor		1 Styl	lill MOG	98	remation and fund 1717 Green Pasture			≘. MD
г	v *		23a. Part1. Enter the disease, or co shock, or heart failure. List on	nplications that caused the de					Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	· much		The state of the s			Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a cons	sequence of):	MYELOMA	1 . /11.	- 12100	,
	LAGITITICI	-	Sequentially list conditions,	b. MULT Due to (or as a cons	sequence of):	MYELOMA	WIME	TAJIASE	,
	nted Insit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	500 10 (0. 00 0 0 0 0 0					
-	be executed ician and burial-tra∩sit	Exa	that initiated events resulting in death) Last	CDue to (or as a cons	sequence of):				
7,60	0 % 0	cal	,	d					
20	certifica Iding ph	siclan/Med	IF FEMALE:						
ŏ n	ath ce attend for us	lan/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pre 1 ☐ Live birth 2 ☐ F 4 ☐ Pregnant at time of	etal death 3	Ectopic pregnancy Other (specify)		23d. Date of de Month	livery Day Year
o.	The law requires that the death ite has been signed by the atter page 2 should be detached for u	hysic	1 □ Yes 2 □ No 9 □ Unknown	9□ Unknown	or death 32	Otter (specify)			
ت. ح	s that ned b	by Pt	Part II. Other significant conditions	contributing to death but not	resulting in the u	nderlying cause given in Part I.	23e. Did tob	acco use contribute to	o the cause of death?
SD	quire; an sìgi uld be						1 ☐ Yes	s 2□No 3□P	robably 4 Munknown
Kecords	law re as bee	plet					24a. Was an autopsy	24b. Were a	utopsy findings available completion of cause of
		Completed					perform 1 ☐ Yes 2	ed? death?	2 LN 0
Vital	Physician: this certific ral director,	Be	25. Was case referred to medical examiner?	Hospital:			ath (Check only one		
_	> .s p	. To	1 ☐ Yes 2 ☑ No 27. Manner of Death	28a. Date of Injury	2 ER/Outpatier 28b. Time of		lome 5 Resider		ecify)
0	ding h. After funer	tlon	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigat	(Month, Day Year		Work? M 1 ☐ Yes 2 ☐ No	200. 2000120 1101	in injury occurred	
Division	Atten r deal ector	iflca	3 Suicide 6 Could not	be 28e. Place of Injury - A	t home, farm, str	eet, factory, office	28f. Location (Str. City or Town,	eet and Number or R	ural Route Number,
ā	tal or s afte al Dir	Certification:	4 Homeloa	building, etc. (Spe	өспу)		City of Town,	Jiale)	
	To the Hospital or Attending Ph within 24 hours alter death. To the Funeral Director: After th completely filled in by the funeral		(Check only 2 Medical Ex	aminer: On the basis of exam	knowledge, death nination and/or in	n occurred at the time, date and place vestigation, in my opinion, death occurred.	e, and due to the cau	use(s) and manner as te and place, and due	s stated. e to the cause(s)
	thin 2 the 1 mplet	Medical	one) 29b. Signature and title of certifier	and manner stated.		29c. License number	29	d. Date signed (Moni	th. Dav. Year)
	F 3 F 8 /	2	· hi	h		0			
1	1		30. Name and address of person wh	o completed cause of death (Item 23a) (Type,	Print)	140	- WEIL	1304 TIMORE
_/	1		STANISLAU	Spivan	MD	SINALHOM	ITAL S	OF BAL	PLUORE
	Sta		31. Date filed (Month, Day, Year)	32Registrar's Si	gnature	B			
	Registr	ar	NOV 2 0 201	14 Macra	19	South			

			1 - For State Registrar	State of Maryl			of H	ealth a		lental Hy	giene Reg. No.	2 U U		36973
, A.	Physici /Medio	cal	Decedent's Name (First, Middle, Last Harold Francis Sav	vage		45 Cit. T		ltion o	f Donth	2. Date of De Month NOVEMB	ER 1	2, 200	4]	Time of Death
	Examir	ner	4a. Facility Name (If not institution, give VA MARYLAND HEALT	H CARE SYST		4b. City, To PERF If Under 1	RY PO			0.0-1(8:-	CI	County of D		
	Funeral Director		5. Social Security Number 6. Se 215-28-6242 Usual Residence of Decedent	X 7. Age (In	yrs. last birthday) 71 Yrs.		Days	Hours	Min.	8. Date of Bir (Month, Da Apr 21	y, Year) 193		Country)	(State or Foreign
	death with the Maryland ima 23a or 28a-f show	Director	10a. State 10b. County MD N/A 10e. Street and Number		.City, Town or Lo		Code				10g. Citi	zen of What	1	nside City Limits Yes 2 No
	nit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan strendt of Health and Mental Hygiene. strendt of Health and Mental Hygiene. orfant: if Item 27 is marked other than "natural; or itema 23a or 28a-f show injury or other traumatic event, the Marical Examinat must be nutilised at injury or other traumatic event, the Marical Examinat must be nutilised at a.	by Funeral	620 E. 31st Street 11. Marital Status 1 Never Married 2 Married 3 Wildowed 4 Divorced	12. Was Decedent Ever Armed Forces? 1 DYes 2 □ No	12. Was Decedent Ever in U.S. Armed Forces? 13. Was 15 No			21210 As Decedent of Hispanic Origin? (Specify Yes, specify Cuban, Mexican, Puerto Rical Yes 2 No Specify:			etc.) Black, Wh		merican In	dian,
21213-0030	be filed within 72 hours after ital Hygiene. id other than "natural", or Ite event, the Medical Examina	Completed	15. Decedent's Edi (Specify only highest grad Elementary/Secondary (0-12)		(Give	dent's Usual kind of work DO NOT use ET	done du retired)	uring most		Shipyard				,
ylaild	should be fill nd Mental Hi marked oth	To Be	17. Father's Name (First, Middle, Last) Clarence Savage	Savage Virginia Hogan										
~	and 2 sh ealth and m 27 is m ner traum		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Tow Mrs. Janet Cornett/Sister 620 E. 31st Street, Baltimore, MD 23								21210			
Dallillore	permit. Pages 1 Department of Hi Important: If Iter any injury or ott		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ F '4 ☐ Donation 5 ☐ Other (Specify)	removal from State	b. Place of Dispo cemetery, crem Chesapeal	ke Cre	mato	ory	N- 2		Belt	sville		State
ם פ	Departition Depart		21. Signature of Funeral Service Licens	ill mod	. 8	717 G	reen	Past	ture	ral Alt s Drive	Ва	tives ltimo:	ce, M	D
	Physician /Medical Examiner		23a. Part1. Enter the disease, or compishock, or heart failure. List only o Immediate Cause (Final disease or condition resulting in death)	ications that caused the one cause on each line. aPNEUMONIA Due to (or as a con		er the mode	of dying	, such as o	cardiac o	r respiratory ar	rest,		Inter	roximate val Between et and Death NOWN
-	te be executed ysician and te burial-transit	ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Causa (Disasted of injury that initiated events resulting in death) Last Due to (or as a consequence of): C. Due to (or as a consequence of):											
	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown 23d. Date of o Month						lelivery Day	Year			
, 5000	w requires that been signed b should be deta	by	Part II. Other significant conditions co.	ntributing to death but not	resulting in the ur	nderlying cau	ise giver	n in Part I.						use of death?
		Completed								24a. Was autop perfor 1 Yes	sy med?	prior to death	o completi	ndings available on of cause of No
VISION OF VICE	Attending Physician: The death. Sector: After this certificate by the funeral director, pag	Certification; To Be	27. Manner of Death 1 X Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Yea		M 280	Other Injury: Work? 1 □ Y	4 □ Nur	sing Hor 2	(Check only on the 5 Residence Resid	ence 6 ow injury	occurred		
	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the		4 Homicide determined	28e. Place of Injury - / building, etc. (Sp sician: To the best of my	ecify)			dota and		28f. Location (S City or Tow	n, State)			te Number,
	To the Hospital or within 24 hours after To the Funeral Dir completely filled in	Medical	(Check only one) 2 Medical Exami	ner: On the basis of exam and manner stated.	nination and/or inv	estigation, ir	my opi	nion, deati	h occurre	ed at the time, o	late and	place, and di	ue to the c	
م		>	30. Name and address of person who co			Print)	5273	39			NOV	EMBER	12,	2004
	Sta		SURESH SHANDELYA, 31. Date filed (Month, Day, Year)	M.D., VA MAI	-	6		E SYS	TEM,	PERRY	POIN	IT, MAI	RYLAN	D 21902
ЭНК	Registr MH 17 Rev 1/2		NOV 2 0 2004	perus	D p	pour	2							

State of Maryland / Department of Health and Mental Hygiere 004 36974 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day 16, 2004 **Physician** 4:00 AM Schader Alan /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Montgomery 9917 Harrogate Rd Bethesda 6. Sex 1 M 2 F If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Feb 4, 19 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. 50 Yrs. 4, 217-46-8801 Florida **Director** Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or Itama 23a or 28a-f show the Medical Examinar must be notified at Bethesda 1 ☐ Yes 2X No Maryland Montgomery Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 9917 Horrogate Rd. 20817 United States death Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status be filed within 72 hours efter di tel Hygiene. d other than "natural", or Itam Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 X No Specify: þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a, Decedent's Usual Occupation 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) Transportation / College (1-4or 5+) Elementary/Secondary (0-12) Airline Company Reservaion Specialist 4 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Heelth and Mentel Hy Important: If Item 27 is marked oth any injury or other traumatic event 9002. 17. Father's Name (First, Middle, Last) Be Schader Betty Argenti Alan James 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3612 Dunlop St., Chevy Chase, MD James G. Oglesby / Friend 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 XCremation 3 Removal from State Chesapeake Crematory 11/18/04 Beltsville, MD * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Rapp Funeral and Cremation Services
933 Gist Ave., Silver Spring, MD Tiplito Kolumann 20910 100382 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** AIDS disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) Examiner -transit Cause (Disease or injury The law requires that the death certificate be executed attending physician and for use as the burial-trar that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) the 9 Unknown þ been signed be should be deta Part II, Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. by Ischemia 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💹 Inknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an Pneumonia this certificate has ral director, page 2 autopsy performed? ŽXNo Wasting Syndrome 1 Yes Division of Vital Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one, Be examiner Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home XX Residence 6 Other (Specify) 2 1 Yes 2 XNo 3 DOA After th 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred Certification; 27. Manner of Death 28b. Time of 1 XNatural 5 Pending 1 ☐ Yes 2 ☐ No 24 hours after death. 2 Accident investigation 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 24 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dav. Year) 25553 November 18 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8630 Fenton St. #230; Silver Spring, MD Phuong Trinh M.D.; 32. Registrar's Signature 31. Date filed (Month, Day, Year) Registrar NOV 2 0 2004

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** INIL /Medical 4b. City, Town, or Location of Death Name (If not institution, give street and number 4c. County of Death **Examiner** timore NOUBHBER 7. Age (In yrs. last birthday) If Under 24 Hrs. 6. Sex 8. Date of Birth (Month, Day Birthplace (State or Foreign Country) **Funeral** Days Min 214-46-796 Usual Residence of Decedent 1 M 2005 59 Yrs. Director 10b. County 10c. City, Town or Location 10a State 10d. Inside City Limits show other treumatic event, the Medical Examiner must be notified at 1 Yes 2 No Directo timore 10f. Zip Code 10g. Citizen of What Country? or items 23a Funeral 14. Race - American Indian DANNIE Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NDT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry d 2 should be filed within 7 h and Mentat Hygiene.
7 Ie marked other than "r Sollege (1-4or 5+) Elementary/Secondary (0-12) 17. Father's Name (First, Middle, Last) torace permit. Pages 1 and 2 Department of Health a Importent: If item 27 Is any Injury or other tre 20b. Place of Disposition (Name of Method of Disposition 1 ■Burial 2 □ Cremation 3 □ Removal from State ⁴ □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not ent shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Co **Physician** CANCER Lon ears disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine burial-transit Due to (or as a consequence of): Physician/Medical Box IF FEMALE If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Month Year 4 Pregnant at time of death 5 Other (specify) P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, by 1 🗌 Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? res 2.2 No 1 ☐ Yes Hospitel or Attending Physicien: 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Cther (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 Pending death. investigation Director: 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated within 2 29d. Date signed (Month, Day, Year) , 29b. Signature and title of certifier November 16,200 x mo who copple d cause of de to tem 23a) (Type, Print) 30. Name and address of person Bolts. Md 2120x Sint 6701 31. Date filed (Manth.

DHMH 17 Rev 1/2001

State Registrar

ORIGINAL

32. Registrar's Signature

Director ō within 24 hours a

31. Date filed (Month, Day, Year) State Registrar

29a, Certifier (Check onto

29b. Signature and

address of person who completed cause of

2004

TREE

29c. License number O.C.M.E.

outs

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year) November 20, 2004

Item 23a) (Type, Print)

111 Penn Street, Baltimore, Maryland 21201 32. Registrar's Signature

			1 1043	State of M			artment of H		and Mental Hy	giene		
		•	For State Registrar		,		tificate of			Reg. No. 2 U U	14	36977
-	Physici /Medic	cal	1. Decedent's Name (First, Middle,	E.		UR	NER		2. Date of De Month	15 20	ear 004	3. Time of Death 4:47pm
1	Examin		4a. Facility Name (If not institution, s SHOCK TRA	nive street and number)		FR	4b. City, Town, or	Location o	OR F	4c. County of	Death	
	Funeral Director				-1-1	last birthday) Yrs.	If Under 1 Year Months Days	If Under 2 Hours	24 Hrs. 8. Date of Bin Min. (Month, Da May 14,	th 9 ay, Year) 1925 M	Birthplac Country (ary1	
	and W		Usual Residence of Decedent 10a. State 10b. County		10c. Cit	ty, Town or Lo	cation				10d	Inside City Limits
	Maryi -f sho	to	Maryland Baltin	nore	Cat	onsvil	1e					1 ☐ Yes 2 No
	or 284	Director	10e. Street and Number 414 Locust Drive				10f. Zip Code	1228		10g. Citizen of Wha	it Country	?
	eath w	Funeral	11. Marital Status	12. Was Decedent	Ever in U	.S. 13.			gin? (Specify Yes or No		American	Indian,
21215-0036	be filed within 72 hours after death with the Maryland stal Hygiene. od other than "netural", or items 23e or 28e-f show od other than "netural", or items 20e or 28e-f show event, the Medical Examination	by	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces?	No		f Yes, specify Cuba 1 ☐ Yes 2 I X No	Specify:	gin? (Specify Yes or No , Puerto Rican, etc.)	Black, Specify:	White, etc Whit	
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	thould be filed to Mental Hygie marked other matic event, III	BeC	17. Father's Name (First, Middle, La						r's Name (First, Middle,			
Maryland	should be and Mental is marked o	2	James E. Turner,			19b Mailir	a Address (Street		s Celestine		ate. Zin Co	ode)
	lth ar 1th ar 27 is 7 trau		Joan W. Turner	Wife					Catonsville			-
Baltimore,	0 0		20a. Method of Disposition 1 XBurial 2 Cremation 3	☐Removal from State	0	cemetery, crei	sition (Name of natory or other place		Date	20c. Location - Cit	•	
ţim	Pa ant Lry		`4 ☐ Donation 5 ☐ Other (Spe	city)	New				11/19/2004			
Bai	permit. Departr Imports any inju		21. Signature of Funeral Service Lie	. Verti		7	36 Edmond	dson A	Schwab Fu Venue; Cat	onsville,	MD :	nc. 21228 oproximate
	Physician		23a. Part I. Enter the disease, which shock, or heart failure. List or Immediate Cause (Final disease or condition resulting in death)	a. SUBD	urf	TL H	EMORR		-	ING FAI	In	terval Between nset and Death
	/Medical Examiner			Due to (or as	a conseq	luence of):	17	7	,			
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	be executed sician and burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c Due to (or as	a conseq	uence of):	CERTIFICATION AND	ROVED	MEDICKE MU	4		
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9			IF FEMALE:	22a Huga autoamar	of proper					1	1722	-
.O. Box	that the death certificat led by the attending phy detached for use as th	Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant a 9 □ Unknown	2 Feta	Ideath 3□	Ectopic pregnancy Other (specify)			23d. Date o Month	f delivery Da	y Year
Δ.	quires that n signed b uld be deta	by	Part II. Other significant condition PNELLMON		out not res	ulting in the u	nderlying cause give	en in Part I.	23e. Did to	obacco use contribu Yes 2 No 3 [eause of death? y 4 □Unknown
Records,	The law requires that the sate has been signed by the page 2 should be detache	Completed	RENAL F	FAILURE						osy prior deal	r to compl th?	findings available etion of cause of
Vital	Physicien: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:			Oth	er	of Death (Check only o			
of	Phys rthis ral dii	.: To	1 ☐ Yes 2 ▼No 27. Manner of Death	28a. Date of Inju		ER/Outpatier	1 JU DOM	4 Nui	sing Home 5 Resid	dence 6 \(\text{Other (} \) how injury occurred	Specify)	
Division	or Attending fater death. Director: After in by the funer.	Certification;	1 □ Natural 5 □ Pending investiga	tion 11/06/2	2004	9:00	ρM 1□		· Fell do	un Stair	50	+ home
ivis	f or Attendatter death Director:	rtific	3 Suicide 6 Could no determine	building, el	c. (Specif	ome, farm, str y)	eet, factory, office		28f. Location (5 City or Tov		or Rural Re	oute Number, Baltimore,
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	edical Ce	29a. Certifier 1 V Certifying (Check only 2 Medicel Ex	Physician: To the best	f examina	owledge, death	occurred at the tin	ne, date and pinion, deat	d place, and due to the the cocurred at the time,	cause(s) and manned date and place, and	or as state	M.D.
	o the vithin 2 o the omplet	Med	29b. Signature and title of certifier	and manner st	otaci		29c. License	e number		29d. Date signed (M	fonth, Day	ı, Year)
	1	~/	Brian	Frene	M	M	0 44	-6°	11(MN)	11/18/2	200	4
1	JX'/	V	30. Name and address of person w	1 100 01	1 .			22	So. Gre	DAR CL	Ba	Itimore,
	Sta	ate	BRIAN FRENCH 31. Date filed (Month, Day, Year)	32. Registr	OCK rar's Signa		a Center	,	. 30.010	CUC 21.	MC	141401
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State of Maryland / Department of Health and Mental Hygiene 36978 For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** 3:45 William Vincent Treherne 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner FRANKLIN SQUARE HOSPITAL CENTER BALTIMORE ROSEDALE If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Ye, May 3, 1921 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 6. Sex Social Security Number Days **Funeral** Months Hours 1 M 2 □ F 212-07-6409 83 Mary land Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "netural", or Items 23a or 28a-4 show any injury or other traumatic event, the Mardical Examplant must be notified at once. Mary land N/A Baltimore 1 X Yes 2 □ No Director 10g. Citizen of What Country? 10f, Zip Code 10e. Street and Number 5607 Mayview Avenue 21206 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No WWII If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 (X) No Specify: Specify: White þ Baltimore, Maryland 21215-003 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15 Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Police Sergeant Baltimore City 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Harry Treherne Mae Veronica McCarthy 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Joanne Treherne/Wife 5607 Mayview Avenue Baltimore Maryland 21206 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Hilltop Service Corp. 11/22/04 Towson Maryland 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Leonard J. Ruck, Inc. 5305 Harford Road Baltimore Maryland 21214 21. Signature of Funeral Service Licensee Christina L. Hilton 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) SEPSIS Physician /Medical Due to (or as a consequence of): Examiner INFECTION BACTERIAL Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed and Due to (or as a consequence of) burial-1 Box 68760, siclan by Physician/Medical the as IF FEMALE: for use 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) P.O. be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, CLOSTRIDUM DIFFICILE 1 Yes 2 No 3 Probably 4 TUnknown AORTIC STENOSIS Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy page 2 1 ☐ Yes 2 X No of Vital or Attending Physicien: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Other: Hospital: 3□ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🗶 No 1 Inpatient 2 ER/Outpatient 0 this 28b. Time of 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: After Division 5 Pending investigation 1 XiNatural 1 ☐ Yes 2 ☐ No M death. 2 Accident within 24 hours after deat To the Funerel Director: 6 Could not be determined 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by 4 - Homicide the Hospitel 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier MD, PhD 11-18-2004 alkal 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) FRANKLIN SQUARE DRIVE, BALTIMORE, MD 21237 ARDEHALI 9000 HOSSEIN 31. Date filed (Month, Day, Year) NOV 2 2 32. Régistrar's Signature Registrar

「スカエアイトル

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiere 1 14 Amend Items 28a-f per Dr., G83/11/12/2004dhb Decedent's Name (First, Middle, Last) 2. Date of Death Month Tramontano rank 0735 A M 2004 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Bayview Baltimore Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1 M 2 ☐ F Days Hours 213-26-2615 83 Yrs. April 17,1921 Italy Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 XYes 2 ☐ No Highlandtown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 514 South Decker Avenue 21224 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: 3X Widowed 4 □ Divorced White

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Captain

the Maryland 7 is marked other than "neturel", or items 23a or 28a-f show treumatic event, the Medical Examinar must be notified at death Baltimore, Maryland 21215-0036 Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. Int: If item 27 Is marked other than " permit. Page Department of Important: If

Physician

/Medical

Examiner

Director

ð

10a. State

15. Decedent's Education (Specify only highest grade completed)

Tramontano

19a. Informant's Name/Relationship (Type, Print)

College (1-4or 5+)

Elementary/Secondary (0-12)

17. Father's Name (First, Middle, Last)

8 years

Peppino

Funeral

Director

Physicia /Medic Examine

Box 68760

P.O.

Division of Vital Records.

or Attending Physicien:

in by the funeral After Certificatic death. after death within 24 hours a

		DOSEDII II.
		20a. Method of Dispo
		ty Burial 2 □ '4 □ Donation 5
OUC9		21. Signature of Fun
		23a. Part1. Enter the shock, or heart
n il		Immediate Cause (F disease or condition resulting in death)
	ical Examiner	Sequentially list conditions, loading to immediate Cause. Enter Underficates or in that initiated events resulting in death) La
	nysician/Med	IF FEMALE: 23b. Was decedent print the past 12 mm 1 Yes 2 9 Unknown
	ted by PI	Part II. Other signific
	Complet	
	To Be (25. Was case referre examiner?
	ר:ייי	27. Manner of Death

3 🗌 Suicide

29a. Certifier

4 Homicide

ate filed (Month, Day, Year)

6 Could not be

Toseph Tramontano 1617 Howard Avenue, Essex, MD. 21221 son sition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Cremation 3 Removal from State November Cardens Of Faith Cemetery 5 ☐ Other (Specify) 5, 2004 Rosedale, MD. 22. Name and Address of Facility
Connelly Funeral HOme Of Dundalk, P.A. eral Service Licensee 7110 Sollers Point Road, Dundalk, MD. e disease or complications that caused the death. Doopt enter the mode of dying, such as cardiac or respiratory arrest, failure. List only one cause on each line. Cardiovasular Arthoscleratio to (or as consequence of): ditions, nediate lying njury sectesian 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery pregnant 3 Ectopic pregnancy onths? Month 4☐Pregnant at time of death 5 Other (specify) No 9 Unknown ant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an autopsy performe 1 Yes 2 No d to medical 26. Place of Death Check onl o e Hospital: ↑ ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 5 Pending 2 Accident investigation

24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No 28d. Describe how injury occurred

16b. Kind of Business/Industry

18. Mother's Name (First, Middle, Maiden Surname)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Miquel Maria Tramontano

Detective Agency

Approximate Interval Between Onset and Death

Year

Location (Street and Number or Rural Route Number, City or Town, State)

DE CALL Bulling

Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[In Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature

Home

caus of death (Item 23a) (Type, Print) Deptof Avenue

32. R istrar's Signatura

DD052393

Emerging Medicine Baltimore MD

State Registra

DHMH 17 Rev 1/200

Medical

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

			1 - For State Registrar	State of Maryland /		nt of Health and te of Death	Mental Hygien	Z U U U	36980
	Physic		1. Decedent's Name (First, Middle, Last)		Tair	110.05	2. Date of Death Month D	ay Year	3. Time of Death
	/Medic Examir		4a. Facility Name (If not institution, give s	(1 1	4b. City	Town, or Location of Dea	November 4	c. County of Deat	
	Funeral Director		5. Social Security Number 6. Sex	M 20 F (OO)	birthday) If Unde Yrs. Months	r 1 Year If Under 24 Hrs Days Hours Min		/ 9 Birt	hplace State propreign
	e Maryland ta-f show tiffed at	ctor	10a. State 10b. County		iwn or Location	· · · · · · · · · · · · · · · · · · ·			10d. Inside City Limits 1 Yes 2 No
	ath with the 23e or 28	Funeral Director	89 N. StREEP	ER St.	10f. Zij	125	10g. C	itizen of What Co	untry?
9600	ges 1 and 2 should be filed within 72 hours after death with the Maryland to f Health and Mental Hygiene. If item 27 is marked other than "natural, or Items 23e or 28a-f show or other traumatic evant, the Medical Examinator must be notified at	þ	1 Never Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent Ever in U.S. Armed Forces? 1	13. Was Dece If Yes, spe	dent of Hispanic Origin? (S cify Cuban, Mexican, Puer 2 No Specify:	Specify Yes or No- to Rican, etc.)	14. Race - Ame Black, White Specify: B	rican Indian, af etc. ACK
2121	fited within 72 P Hygiene. other than "nati ant, the Medica	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	ation completed) College (1-4or 5+)	ia. Decedent's Usu (Give kind of wo	ork done during most of wa	orking 16b. 1	Kind of Business/	OKIKS
Maryland	should be fift and Mental H Is markad ott sumatic evan	To Be	DAVIO JONES			INEI	me (First, Middle, Maife HARQU		
	1 and 2 sh Health and Iem 27 Is m	00000	19a, Informant's Name/Relationship (Type)	3	14 NSt	(Street and Number or Ri	St. BAILOI	br Transi State, Z	(ip Code) 1/205
Baltimore,	Pa Int		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Re 1 ☐ Donation 5 ☐ Other (Specify)		of Disposition (Nai egy, crematory or a S NEW C	WAIPK 11-8	3-04 W	ocation - City or	Town, State
Bal	permit. Pag Department Important: any injury once.		21. Signature of Funeral Service (ce) is	Salmore	22. Name ar	nd Address of Facility	AVE BAH	XLLSUK D. W.C. o	21202
ŭ	Physician		23a. Part1. Enter the disease, or complic shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	ations that caused the death. Do	o not enter the mod		c or respiratory arrest,		Approximate Interval Between Onset and Death
	/Medical Examiner	16	Sequentially list conditions, b. if any, leading to immediate	Small Bob Due to (or as a consequence	ver t	schemic			Iweek
8760,	cate be executed physician and the burial-transit	ıl Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to for as a consequence	emia				Zweeks-
		Medical	d.						
.O. Box	that the death certifi ed by the attending detached for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal deat 4 ☐ Pregnant at time of death 9 ☐ Unknown	th 3 □Ectopic pr 5 □ Other (sp			23d. Date of delik Month	very Day Year
ords, P	law requires that the as been signed by th 2 should be detache	by	Part II. Other significant conditions cont	ributing to death but not resulting	in the underlying c	ause given in Part I.		use contribute to	the cause of death?
$\mathbf{\alpha}$	The ate h page	e Completed	25. Was case referred to medical				24a. Was an autopsy performed?	prior to co	opsy findings available ompletion of cause of
of Vital	ys die	To B	examiner?	spital: 1 Appatient 2 ER/O		A Other: 4 Nursing H	ome 5 Residence		ify)
Division	ding h. After fune	atlon	27. Manner of Death Natural 5 Pending investigation	28a. Date of Injury (Month, Day Year) 28b.	Time of 2 Injury M	8c. Injury at Work? 1 Tyes 2 No	28d. Describe how inju	ry occurred	
-	i te	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, f building, etc. (Specify)	arm, street, factory	, office	28f. Location (Street ar City or Town, State	nd Number or Run)	al Route Number,
	To the Hospital of within 24 hours at To tha Funeral D completely filled is	edical	29a. Certifier Check only one) Certifying Physical Exemination	cien: To the best of my knowledg ir: On the basis of examination a and manner stated.	e, death occurred and/or investigation,	at the time, date and place in my opinion, death occu	, and due to the cause(s rred at the time, date and) and manner as s d place, and due t	stated. to the cause(s)
•	To the withing the second company.	¥	29b. Signature and title of certifier	Pan, M.D	290	License number		te signed (Month,	
	10		30. Name and address of person who con BRUCE TAN, W.D.	pleted cause of death (Item 23a) The John	(Type, Print)	1> Hospital			Ho, MO ZIEST
	Sta Registra	te ar	31. Date filed (Month Day, Year) NOV 2 Z 2004	32. Registrar's Signature	Sport	2	<u> </u>	14504 17	140, MD (16)

			For State Registrar	State of Mary	/land /	Depai <i>Cert</i>	rtment of H	lealth and Death		jiene 0 () 4	36981	
	Physici /Medic		Decedent's Name (First, Middle, Last)	Stel	she	n	Upi	man	2. Date of Dea Month	Day O	Yeer Zoo4	3. Time of Death \$\int \cdot \cho \int M\$	
	Examin		4a. Fecility Name (If not institution, give str	eet and number)	Cen	ter	4b. City, Town, or	Location of Dea	more	4c. County of	of Death		
	Funeral Director		5. Social Security Number 6. Sex	7. Age (h	n yrs. last b 95	Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min		Year) 1908	9. Birthpla Country Mary]		
	yland now		Usual Residence of Decedent 10a. State 10b. County	10	Dc. City, To	wn or Loca	ation				100	d. Inside City Limits	
	he Mar 8a-f et	Director	MD Baltimore		Caton	svil:				000		1 □ Yes ※XXNo	
	with t	i Dir	10e. Street and Number 2017 Rockwell Ave.				10f. Zip Code 2122	8		0g. Citizen of W	nat Countr	y?	
920	should be filed within 72 hours after death with the Marylan and Mental Hygiens. The marked other than "natural", or items 23a or 28a-f ehow matic event, in a Madical Examinar must be notilling at	by Funerai		Was Decedent Eve Armed Forces? 1 X Yes 2 □ No If Yes, Give Year or Date 194					Specify Yes or No- to Rican, etc.)	14. Race Black	- American White, et	c.	
Maryland 21215-0036	filed within 72 hours after death with the Maryland Hygiene. other than "natural", or items 23a or 28a-f ehow ent, it a Mazical Examiner must be mailliad at	Completed	15. Decedent's Educal (Specify only highest grade of Elementary/Secondary (0-12)	ion ompleted) College (1-4or 5+)	npleted) (Give kind of work done during mo		ation during most of wo	orking	16b. Kind of Bu		stry		
d 2	filed v Hygie other t	Be Co	12 17. Father's Name (First, Middle, Last)	_	B	OOKK	eeper	18. Mother's Na	me (First, Middle, i	Account			
ylan	d 2 should be filed with and Mental Hygiene 7 is marked other that traumatic event, it a	To B	Stephen Francis Upm						a (Tibba				
Mar			19a. Informant's Name/Relationship (Type Katherine I. O'Neil	•					ural Route Number consville			Code)	
altimore,	permit. Pages 1 and 2. Department of Health ar important: If item 27 is eny injury or other trau		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Ren 1 4 ☐ Donation 5 ☐ Other (Specify)	:	cemet	ery, crema	tion (Name of atory or other place rk Cemet		20/01	20c. Location - (n, State	
Balti	permit. Departn imports eny inju		21. Signature of Funeral Service hicensee	labor	_	730	Name and Addres 6 Edmond	son Ave.	erling A	shton Sore, MD	byaba	F. H. Inc	
	Physician /Medical		23a. Part 1. Enter the disease, or complica shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)	tions that caused the cause on each line.	D-e1	nei	the mode of dyin	g, such as cardia	c or respiratory arm	est,	li C	Approximate Interval Between Driset and Death	
	Examiner	ler	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a co	onsequence	e of):							
oʻ	cate be executed physician and the burial-transit	Examiner	cause. Enter Orderlying Cause (Olsease or injury that initiated events resulting in death) Last	Due to (or as a co	onsequence	e of):							
68760,	ficate be physicials as the but	edicai	d.										
P.O. Box	The law requires that the death certificate be executed tie has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	. If yes, outcome of p 1□Live birth 2 ☐ 4□Pregnant at tim 9□Unknown	Fetal deat		Ectopic pregnancy Other (specify)			23d. Date Mon	of delivery th D	ay Year	
Ś	uires that signed b id be deta	by	Part II. Other significant conditions contri	buting to death but n	ot resulting	in the und	derlying cause give	en in Part I.		oacco use contri es 2 □ No	bute to the	1	
I Record	The law requir	Completed	anemia						24a. Was a autops perform	njeg? pr	/ere autops flor to comp eath? Yes 2	y findings available pletion of cause of	
Vita Vita	ysician: Th	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	pital:	2 🗆 ER/C	\	3□ DOA Oth	74700	ath (Check only on	and the same	. (0		
Division of Vital	tending Physeleath. Ior: After this the funeral di	\vdash		28a. Date of Injury (Month, Day Ye	28b.	Time of Injury	28c. Injun Worl	/ at	Home 5 Reside 28d. Describe ho				
Divisi	or Attendate death Director:	Certification	3 Suicide 6 Could not be determined	28e. Place of Injury building, etc. (5	- At home, Specify)	farm, stree			28f. Location (St City or Town	reet and Numbe n, State)	r or Rural F	Route Number,	
_	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifics completely filled in by the funeral director.	edical C	29a. Certifier (Check only one)	ian: To the best of m : On the basis of ex and manner stated	amination a	ge, death on inve	occurred at the tin estigation, in my of	ne, date and place pinion, death occ	e, and due to the caurred at the time, d	ause(s) and man ate and place, ar	ner as state nd due to th	ed. ne cause(s)	
	To the within 2	Me	29b. Signature and title of certifier	Wi-	7	mo	29c. Licenso	number	91 1	9d. Date signed	(Month, Da	y, Year)	
(+/0		30. Name and address of person who com	bleted cause of death	h (Item 23a		rint)	paltim	iore 1	Mary (a	ind	75515	
	Sta Registr		31. Date filed (Mpnth, Day, Year) NOV 2 2 20	32. Registrar's	Signature	13	Spa	de					
		_	11010	-									

			1 - For State Registrar	State of Ma	iryiana / Depi <i>Ce</i>	artment of H rtificate of L		ntal Hygjei Reg.		30302
	Physici	an	Decedent's Name (First, Middle, Last, EVELYN	Ι.	WOLAK			2. Date of Death Month	Day Year	3. Time of Death
7	-/Medic		4a. Facility Name (If not institution, give		WOLAK	4h Gib. Town		JVEMBER		
	Examin	er	Saint Joseph	·	Center		Location of Death		4c. County of Dea Bal	timore
	Funeral Director		217 10 0720		(In yrs. last birthday) 78 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. B	Date of Birth Month, Day, Ye. Feb. 22, 1	9. Bir 926 Ma	thplace <i>(State or Foreign</i> ountry) ryland
	and *		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	ecation				10d. Inside City Limits
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23e or 28e-f ehow any injury or other traumatic avant, I'm Medical Ever intermist be neithed at once.	tor	Maryland Anne Ar	rundel	Pasad					1 ☐ Yes 2 No
	or 28	Director	10e. Street and Number			10f. Zip Code	-	10g.	Citizen of What C	ountry?
	ath w		1151 Valley Drive			211			U.S.A.	
	er de Items	nne		12. Was Decedent E Armed Forces?	ver in U.S. 13.	Was Decedent of Hi If Yes, specify Cubai	spanic Origin? (Speci n, Mexican, Puerto Ri	fy Yes or No- can, etc.)	14. Race - Ame Black, Whi	
Maryland 21215-0036	urs aft	by Funerai	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☑ N If Yes, Give Year or Dates:	0	1 ☐ Yes 2 No	Specify:		Specify: W	nite
20	72 ho	Completed	15. Decedent's Edu (Specify only highest grad	cation	16a. Dece	dent's Usual Occupa	ition	16b.	Kind of Business	/Industry
2	nithin nen	npie	Elementary/Secondary (0-12)	College (1-4or 5-	/ife.	DO NOT use retired,	uring most of working ASS	st. B	& O Rai	Iroad
2	iled w lygier iher ti		12 17. Father's Name (First, Middle, Last)	0	Execu		inistrati	ve		
anc	d be finited by	Be C	Charles Wis				18. Mother's Name (I			
7	should bd Me mark imatic	은	19a. Informant's Name/Relationship (Ty		19b. Mailir	ng Address (Street a	nd Number or Rural F			Zin Code)
	nd 2 :		Ronald A. Wolak				Drive, Ha			
ore,	as 1 a of Hea item		20a. Method of Disposition		20b. Place of Dispo	sition (Name of	Dat	C	Location - City or	
Baltimore,	Page tment c tant: If jury or	3	1 Burial 2 □ Cremation 3 □ P '4 □ Donation 5 □ Other (Specify)	1	Loudon Pa	rk Cemete	ry 11-22-	-04 Bal	timore,	Maryland
Bal	Depar Impor any in		21. Signature of Funeral Service Lives	umm	Mc Mc	Name and Address Cully—Pol 204 Mounta	lyniak Fung ain Road.	eral Home Pasadena	e P.A. Marvlan	nd 21122
			23a art1. Enter the disease, or complishock, or heart failure. List only or	ications that caused the cause on each line	the death. Do not ent	er the mode of dying	, such as cardiac or r	espiratory arrest,		Approximate Interval Between
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L		-	Sequentially list conditions,		RY ARTER	Y BYPASS	6 GRAFTIN	4G		
	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events		RY ARTER	5.7 PS Tr (PS 200 25 27	the proces			
o,	tificate be executed to physician and as the burial-transit		resulting in death) Last		consequence of):	A Disel s	1 100			
68760,	ate be hysicii the bu	ledicai		t						
	ertific ling p		IF FEMALE:							
Вох	death ce ne attendii ad for use	ian/	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of 1 Live birth 2	Fetal death 3	Ectopic pregnancy			23d. Date of del Month	ivery Day Year
P.0.	res that the death cer igned by the attendir be detached for use	Physician/	1 ☐ Yes 2 XNo 9 ☐ Uлknown	4∐Pregnant at t 9☐ Uлклоwn	ille of death 5	Other (specify)				
	s that ned b e deta	by Pt	Part II. Other significant conditions cor	ntributing to death but	t not resulting in the u	nderlying cause give	n in Part I.	23e. Did tobacci	use contribute to	the cause of death?
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eco	has bei	Completed						24a. Was an autopsy		topsy findings available completion of cause of
	The ate h page	Con						performed?	death?	3.0
Vital	Physician: r this certific ral director,	Be	25. Was case referred to medical examiner?	la anitalı .			26. Place of Death (C	Check only one)		
of	Phys this al dir	T _o	1 ☐ Yes 2 No	lospital: 1 Inpatien 28a. ate of Injury			4 C Norsing Home			cify)
O	ding th. After funer	tion	1 Natural 5 Pending 2 Accident investigation	(Month, Day	Year) Injury	28c. Injury Work' M 1 T	es 2 No	f. Describe how in	ury occurred	
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ā	tal or	Certification;	4 nonlicide	building, etc.	(Specify)			City or Town, Sta	ite)	
	To the Hospital or Attanding Physician: The I within 24 hours after death. To the Funaral Diractor: After this certificate he completely filled in by the funeral director, page	edicai	29a. Certifier (Check only one) 1 Certifying Physical Examination (Check only one)	sicien: To the best of ner: On the basis of e and manner state	my knowledge, death examination and/or inved.	occurred at the time estigation, in my opi	e, date and place, and inion, death occurred	due to the cause at the time, date a	s) and manner as nd place, and due	stated. to the cause(s)
	To the comp	Me	29b. Signature and title of certifier		117	29c. License	n <i>u</i> mber		ate signed (Month	
)			Men	2	0	D 30	1263	1	1-19-0	4
1	9		30. Name and address of person who co	mpleted cause of de	ath (Item 23a) (Type,		worth Step" Sept			
_			31. Date filed (Month) Para Year) O	D 7691	OSLER D	RIVE JON	ISON MARY	LAND 21	204	
	Sta Registra		NUV222	OC4 32. Registrar	's Signature	Spark	621			

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Dav Year Physician 3:00a M **NOVEMBER** BEATRICE 21 2004 Ε, WILKE /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner BALTIMORE 619 BISCAY AVE. ANNE ARUNDEL CO. 8. Date of Birth (Month, Day, Yea 4-25-1924 Birthplace (State or Foreign Country) If Under 1 Year Months Days 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Hours Year) 1 □ M 2 ☐ F Virginia 80 Director 228-22-6708 Usual Residence of Decedent death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a State ral, or Items 23a or 28a-f show Examiner roust be notified at 1 ☐Yes 2 No Directo Maryland Anne ARundel **Baltimore** 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 21225 Funerai 619 Biscay Ave. 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. 1 ☐ Yes 2 1 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: ģ 3 Widowed 4 □ Divorced White "natural" ntal Hygiene. ed other than "natura s event, the Modical E Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker n/a 3 years 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Is marked Vera Lee (unknown) James Straton Turner ္ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 346 Carronade Way Arnold, Maryland f Health item 27 I other tra <u>Billy Wilke (son)</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1 Department of H Importent: If ite any injury or otl 1 Burial 2 □ Cremation 3 □ Removal from State Meadowridge Mem. Pk. 11-24-2004 Elkridge, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature di Funeral Service Licensee McCully-Polyniak Funeral Home, P.A. 130 E. Fort Ave. Baltimore, Maryland 21230 moog 22 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Due to (or as a consequence of): NI /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner The law requires that the death certificate be executed the attending physician and thed for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Year in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day be detached for 5 Other (specify) 9 Unknown been signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of ause of death? 24a. Was an autopsy performed? Yes 2 No has 2 3 No 1 ☐ Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home Certification: To 5 Residence 6 ☐Other (Specify) 1 Tyes within 24 hours after death.

To the Funeral Director: After th
completely filled in by the funeral 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide within 24 hours a To the Funeral L 🗺 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D19640 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HANOVER IT W 1 31. Date filed (Month, Day, Year) 32. Registrar's Signature State NOV 2 2 2004 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician OCTOBER 8, 2004 Charles S. Wilson 6:07 P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** 18 REEDBIRD AVE BALTIMORE CITY 8. Date of Birth (Month, Day, Year)
May 19, 19 5. Social Security Number Unk If Under 1 Year | If Under 24 Hrs. Funeral 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Months Days Hours Min. 1⊠M 2□F 56 Yrs. Director Maryland Usual Residence of Decedent with the Maryland 10b. County 10c. City. Town or Location 10d. Inside City Limits 10a. State itam 27 is markad other than "natural", or Itams 23a or 28a-1 show othar traumatic evant. The Medical Examinar must be notified at MD Anne Arundel Glen Burnie 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 391 Old Stage Road 21061 USA by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after Hygiene. 168-70 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: black 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b, Kind of Business/Industry d 2 should be filed within 7 in and Mental Hygiene. 7 Is markad othar than "r Elementary/Secondary (0-12) College (1-4or 5+) truck driver construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be George Wilson Eddie Ruth Finch 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 s ment of Health an ant: If itam 27 Is Karen Wilson/daughter 2876 Mayfield Avenue Baltimore, MD 21213 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State ō permit. Page Department of Important: If any injury or once. `4 □Donation 5 \$\ Other (Specify) in state 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 21. Signature of Funeral Sovice Licensee Romand S. Wade rau 23a. Part1. Enter the disease, or/complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician * IUTRACEREBELLAR HEM ORRHAGE /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner as the burial-transit certificate be executed Due to (or as a consequence of): the attending physician Division of Vital Records, P.O. Box 68760 ian/Medical IF FEMALE: esn 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death Physici 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Nuckhown Completed 24b. Were autopsy findings available prior to completion of cause of certificate has autopsy performed? Yes 2□ No 2 No Hospital or Attanding Physician: 24 hours after death. Funaral Diractor: After this certifice 25. Was case referred to medical 26. Place of Death Check onl one examiner' Other: 4 Nursing Home 5 Residence W ther (Specify) SCENE 1XX Yes 2 ☐ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of Certification; 28d. Describe how injury occurred Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 24 hours a 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier cal (Check only one) 2XXMedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) OCME MO OCTOBER 9, 2004 Mulyante

State Registrar

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31. Date filed (Month, Day, Year)

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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111 Penn Street, Baltimore, Maryland 21201

		-	For State Registrar	State of Man		artment of H			ene 00	4	36985
	Physicia	_	1. Decedent's Name (First, Middle, Last)					2. Date of Death Month	Day Y	rear ,	3. Time of Death
Ŋ	/Medic	al	Dorothy S. Windso			4b City Town or	Location of Death	//	20 C	Death	9.20 M
	Examin	er	St agnes 1	Leathe	evel	Balle	more		n/		
	Funeral Director		213 07 3777	7. Age (I	n yrs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,)	Year) 919 M	9. Birtholo Count lary1	
	land ow		Usual Residence of Decedent 10a. State 10b. County	10	Dc. City, Town or Lo	ocation				10	Od. Inside City Limits
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Maryland	should be nd Mental marked o	To	Walter R. Shipley					h Dennsta			
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altimore,	Pages ment of ent: If it ury or o		¶ Burial 2 □ Cremation 3 □ F '4 □ Donation 5 □ Other (Specify)	Removal from State	Loudon I	patory or other place ark Cemet	ery 11-	23-2004	3620 Wil Baltimor	lken:	s Ave.
Balt	permit. Pag Department Importent: I eny injury o	1	21. Signature of Funeral Service cens	lange	1	3620 Wi	Park Fun 11kens Av	eral Home e. Baltin	nore. Mo	1	
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Division	el or Atte s after des il Directo	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury building, etc. (- At home, farm, st (Specify)	reet, factory, office	## 75	28f. Location (Stre City or Town,	eet and Number State)	or Rural	Route Number,
	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certific completely filled in by the funeral director.	edical (rsician: To the best of r iner: On the basis of ex and manner state	camination and/or in						
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	01.		an Name and address of a page who a	ompleted cause of dear	th (Item 23a) (Type		10012	10	COLMIC	0	0, 2004
	70			is frederic) , YUG ATIO	MOUSULL	EMO:	21938		
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State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) **Physician** 16 November 12:50P. C. Weston Margaretta /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore St. Charles Catonsville 717 Maiden Choice Lane; If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** 1 ☐ M 2 🔀 F 20,1922 216-14-4525 New York 82 **Director** Usual Residence of Decedent permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mental Hygiene. Importent: if tiem 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Expirimet must be continued as 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 ☐ Yes 2 No Directo Maryland Baltimore Catonsville 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21228 717 Maiden Choice Lane; St. Charles U.S.A. Funerai 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 No 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 Yes 2K No Specify: If Yes, Give Year or Dates: White þ 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Telephone Company Telephone Representative 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Clara Unknown Herbert Cake ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 293 Hickory Ridge Drive Queenstown, Maryland 21658 Laura L. Boulay (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Balto./Wash. Crematory 11-17-04 | Laurel, Maryland ^¹ 4 □ Donation 5 □ Other (Specify) Witzke Funeral Home of Catonsville, Inc. 1630 Edmondson Avenue Catonsville, MD 21228 21. Signature W01290 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final NEOPL MONTIS OF **Physician** ASM resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician Completed by Physician/Medical as the IF FEMALE: esn 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 DEctopic pregnancy Live birth Year Month Dav jo in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 No detached the 9 Unknown ģ 23e. Did tobacco use contribute to the cause of death? Part II, Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed should be 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has 2. No 1 Yes 2 No certificate 1 Yes Physician: completely filled in by the funeral director, To Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 2 **S** 4 Nursing Home 5 Residence 6 □Other (Specify) 1 ☐ Yes 2 ☐ ER/Outpatient 3□ DOA this 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death Medical Certification: or Attending Injury Natural 5 Pendina 1 ☐ Yes 2 ☐ No investigation death. 2 Accident within 24 hours after deal To the Funerel Director: 6 Could not be determined 3 ☐ Suicide 28l. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signathre and title of qertifier NOVEMBER 17. 40012 30. Name and adjurass of person who completed cause of death (Item 23a) (Type, Print) CATONSOILLE MO 21298 Soure Doy 405 Frederick NO Scoll 31. Date filed (Mo 32. Registrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene 004 36988 1 - Stete Registrar Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year Walker 07:27 PM **Physician** Frederick 2004 Grordon /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Boltimore Baltimore Hosp: Kernen If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (Sta Country) April 24,1919 Maryland Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours 117 M 2□ F 85 220-01-2929 Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County itsm 27 is marked other than "natural", or itema 23a or 28a-f show other traumatic event, the Medical Examinar must be notified at 1 ☐ Yes 2 No Director Baltimore Caton Manor Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21207 U.S.A. 5905 Carroll Street Funerai Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 Armed Forces? 1 Yes 2 No WW II 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be tiled within 72 hours after t Department of Health and Mental Hygiene. Important: If itsm 27 is marked other than "natural", or ites any injury or other traumatic event, the Medical Examinal once. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Baltimore, Maryland 21215-0036 þ White 3 Nidowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Driver Construction 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Luraye Bradshaw Unknown Wachter 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Susan Burns 977 Southridge Road Catonsville, Maryland 21228 (Daughter) 20b. Place of Disposition (Name of cemetery, cremajory or other place)
Crownsville Veterans
Cemetery Date 20c. Location - City or Town, Stete 20a. Method of Disposition 1

Burial 2

Cremation 3

Removal from State 11-22-04 * 4 □ Donation 5 □ Other (Specify) Crownsville, Maryland 21. Signature of Funeral Service License 22. Name and Address of Facility. Witzke Funeral Home of Catonsville, Inc. Deman 1630 Edmondson Avenue Catonsville, MD 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death erebrol Immediate Cause (Final Vascular Zych Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to for as a consequence of Examiner The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): physician s the burial Division of Vital Records, P.O. Box 68760, Physician/Medical attending IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months?
1 Yes 2 No 4☐ Pregnant at time of death 5 Other (specify) 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Š 1 ✓ Yes 2 □ No 21 Cer 3 Probably 4 DUnknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed2 1 Yes 2 No 2 No certificate or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA Certification: To **Juneral** dir 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No death. investigation 2 Accident Director: filled in by the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 🗌 Homicide within 24 hours a To the Funeral L 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and the of certifier D0044635 $\mathcal{N} \cdot \mathcal{D}$ 18/ 2004 who completed cause of death (Item 23a) (Type, Print) 30. Name and address of person Drive , Baltimore , Md. 21207 2200 nn arrisen Ò 31. Date filed (Month, Day, Y 32. Registrar's Signature State Registrar

			1 - For State Registrar	State of Marylan			t of Hea e of De			jiene 1eg. No.	2004	36989
	Physici	an	1. Decedent's Name (First, Middle, Last)		()	ع ا ر	2017		2. Date of Dea Month	Day	Year	3. Time of Death
	/Medic Examin	-	4a. Facility Name (If not institution, give	street and number)		- 10		cation of Death	Novem		County of Deat	
	Examili	e	Johns Hopkins B	alview Care.	Conta	Bal	Hime	ore C	i+y _		N/A	
	Funeral Director		5. Social Security Number 6. Sec	7.44.	last birthday) Yrs.	If Under Months		Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day Dec. 1	Year)	9. Birtl Co M	hplace (State or Foreign untry) aryland
	pu 🛦		Usual Residence of Decedent 10a, State 10b, County	10c, Cit	y, Town or Loc	ation						10d. Inside City Limits
	Maryla f sho	ō	Maryland Balti	more			Mil	lers Is	land			1 ☐ Yes 2 🌣 No
	288-	rect	10e. Street and Number			10f. Zip	Code			10g. Citiz	en of What Co	untry?
	h with	a D	8909 Cuckold Poi	nt Road				21219		Unit	ted Sta	tes
36	s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. I health and Mental Hygiene. Itam 27 is marked other than "netural; or Itams 23s or 28s-f show item 27 is marked other than "netural; or Itams It	by Funeral Director	11. Marital Status 1 □ Never Married 2√2 Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in U Armed Forces? 1∑Yes 2 ☐ No If Yes, Give Year or Dates: WWII	1	/as Deced Yes, spec		anic Origin? (Sp Mexican, Puerto Specify:	pecify Yes or No- Rican, etc.)	1	Race - Ame Black, White Specify:	
Maryland 21215-0036	hin 72 hou s. an "natura Wedical E	Completed	15. Decedent's Edu (Specify only highest grad	cation	16a. Decede	and of wo	al Occupation Ink done during se retired)	n ng most of wort	king		nd of Business/	
7	e filed within 7 al Hygiene. I other than "r vent, the Well	Con	4 Years		Sl	nippi		. M-M	- /Final Middle		eel Ind	ustry
land	should be fill and Mental Hy s markad oth numatic event	To Be	John Bass				18		ne (First, Middle, a Leona l			
Mary	nd 2 should be lith and Mental 27 is markad r traumatic ev		19a. Informant's Name/Relationship (T) Mrs. Marguerite					Number or Ru Point F	ral Route Numbe Road Mi		Town, State, 2 s Islan Marylan	
ore,	permit. Pages 1 and Department of Health Important: If itam 27 any injury or other ti 200.2.		20a. Method of Disposition 125 Burial 2 Cremation 3 F	20b. F	Place of Dispos	atory or o	ther place)		Date	20c. Loc	cation - City or	Town, State
Baltimore,	mit. Pag partment portant: rinjury :		* 4 □ Donation 4 5 □ Other (Specify) 21. Signature 4 Puneral Service License	A	22.	Name an	nd Address of	of Facility	1/19/20			
ä	P P P S		Mesegorn E	Keed	170	922 W	Vise A	ve. Du	Home of ndalk, N	Mary		1222
	Physician /Medical Examiner		23a. Part 1. Enter the disease, or comp shock, or heart failure: List only of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate	a. A ght may Due to (or as a consect	(Var v			ouch as cardiac	to the second		oma	Approximate Interval Between Onset and Death MON + DS
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.O. Box 6	at the death certific by the attending plached for use as t	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of pregn. 1 Live birth 2 Fete 4 Pregnant at time of c	al death 3 🗌	Ectopic pi Other (sp				2	3d. Date of del Month	ivery Day Year
Δ.	ires that signed b d be deta	þ	Part II. Other significant conditions co	ntributing to death but not res	sulting in the un	derlying o	ause given	in Part I.		obacco u 'es 2[3.4	the cause of death?
Records,	e law requir has been si je 2 should	Completed	The state of the s	1					24a. Was	SV	prior to	utopsy findings available completion of cause of
<u> </u>	The I	Son							1 ☐ Yes	2 No	death?	2 □ No
Vital	certifica rector. p	Be	25. Was case referred to medical examiner?	Hospital:			Other		th (Check only o			
of	shys this al dii	2	1 Yes 2 No	28a. Date of Injury	ER/Outpatient 28b. Time of		DA 28c. Injury a		ome 5 Resid			city)
U	After Une	tion	Natural 5 Pending 2 Accident investigation	(Month, Day Year)	Injury	М	Work?	s 2 🗆 No				
Division	of or Attanding after death. I Director: After din by the fune	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h building, etc. (Speci		et, factor	y, office		28f. Location (S City or Tox			ural Route Number,
_	To the Hospital or A within 24 hours after To the Funeral Dire completely filled in b	Medical C	29a. Certifier NCertifying Phy (Check only one)	ysician: To the best of my kniner; On the basis of examination and manner stated.	owledge, death ation and/or inv	occurred estigation	at the time, n, in my opin	date and place	, and due to the orred at the time,	cause(s) date and	and manner as place, and due	s stated. e to the cause(s)
	Fo the within Fo the comple	Me	29b. Signature and title of certifier	,		29	c. License n				e signed (Mont	
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16	$0_{A_{i}}$		30. Name and address of person who o			Print) ✓ ()	13	ALTIN	TORE	Mo	217	224
	St Regist	ate	31. Date filed (Month, Day, Year)	32. Registrar's Sign		So	and	,				

		1 - For Stete Registrar	Otate of	Maryland / [Certificate				ne No2004	3699
Physic /Med		Decedent's Name (First, Middle, I		a Mary Wi	lliamson		M	ate of Death onth vember	Day Year 16,2004	3. Time of Death
Exami		4a. Facility Name (If not institution, g	give street and numb	oer)	4b. City, Tow	vn, or Location	of Death		4c. County of Dea	
		Stella Maris Ho			hday) If Under 1 Y	TOWSO:		ato of Righ	Balti	
Funeral Director	•	213-05-0210	.Sex 7. 1 □ M 21X F	Age (In yrs. last birt		ays Hours	Min. (A	ate of Birth fonth, Day, Ye g • 23 ,]		rthplace (State or Foreig country) aryland
A I		Usual Residence of Decedent 10a, State 10b, County		10c. City, Town	or Location					10d. Inside City Limit
fah	Ď	Marriand Bali	timore			Essex				1 ☐ Yes 21X N
r 28a	Director	Maryland Balt 10e. Street and Number	LIMOLE		10f. Zip Cod			10g.	Citizen of What C	ountry?
23a o		800 Baltimore	e Yacht C	lub Road		21:	221		United S	States
Department of Health and Mental Hygiene. Importent: It item 27s or 28a-f show importent: It item 27 is marked other then "natural", or items 23a or 28a-f show any injury or other treumetic event, the Medical Evant at must be notified at once.	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3€35Widowed 4 □ Divorced	12. Was Deceded Armed Force 1 Yes 2 If Yes, Give Year or Date	es? XENo	13. Was Decedent If Yes, specify (es or No- etc.)	14. Race - Am Black, Whi Specify:	
"nature	Completed	15. Decedent's (Specify only highest of	grade completed)		Decedent's Usual Od (Give kind of work do life. DO NOT use re	ccupation one during mos	st of working	16b	o. Kind of Business	/Industry
r ther	omp	Elementary/Secondary (0-12) 3 Years	College (1-4	or 5+)	Seamtress				Upholste	erv
othe ont,	(a)	17. Father's Name (First, Middle, La	st)				er's Name (Firs	, Middle, Maid		-
Menta rrkad	To B	Harry Wdziecz	na			i	Josephin	ne Ladi	isjczyk	
alth and I	19a. Informant's Name/Relationship (Type, Print) Son Mr. Reese F. Williamson, Jr. 800 Baltimore Yacht Club Road Essex									
ment of He ent: If item lury or oth		20a. Method of Disposition 1 🖾 Burial 2 Cremation 3 4 Donation 5 Other (Special Control of Contr	city)	ate cemeter	Disposition (Name of contract of the contract	ery 11,	Date /20/2004	1		Town, State e, Marylan
Depart Import any inj once.		21. Signature of Funeral Service Lice	ensee M	0011	22. Name and Ad Duda-Ruc 7922 Wi	ddress of Facili k Fune:	ral Home	e of Du	ındalk, I	nc. 21222
nysician Medical	3	Immediate Cause (Final								Interval Between Onset and Death
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nysicien and he burial-transit	Examiner	resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or	as a consequence of	f):					
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			For State Registrar	State of Mary		rtment of H tificate of L		1ental Hygie	71111	4 36991			
	Physicia		1. Decedent's Name (First, Middle, Li	•	WILLS	* '.		2. Date of Death Month		3. Time of Death			
	/Medic Examin		4a. Facility Name (If not institution, gi				Location of Death		4c. County of				
			JOHNS HOPKIN				IMORE			MORE CITY			
	Funeral			Sex 7. Age (Ir 1☑M 2□F 40	yrs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day You Jan. 29,	1964	D. Birthplace (State or Foreign Country) Maryland			
	Director		212-90-9260 Usual Residence of Decedent						1	alyland			
	irylane show	_	10a. State 10b. County		c. City, Town or Loc		3 - 3 1-			10d. Inside City Limits 1 ☐ Yes 2 ☐XNo			
	he Ma	Director	Maryland Ba. 10e. Street and Number	ltimore		Dunc 10f. Zip Code	Id IK	100	Citizen of Wh				
	with t		7823 St. Grego:	ry Drive		Toi. Zip Code	21222	-	United				
	death	Funerai	11. Marital Status	12. Was Decedent Ever Armed Forces?	r in U.S. 13. V	Vas Decedent of Hi	ispanic Origin? (Sp n, Mexican, Puerto	ecify Yes or No-		American Indian, White, etc.			
98	4 within 72 hours after death with the Maryland jiene. r than "natural", or Itams 23e or 28e-f show The Medical Examinet must be ructified at	by Fu	1 Never Married 2 Married	1 ☐ Yes 2 🔯 No If Yes, Give		☐ Yes 2⊠ No		,,	Specify:				
21215-0036	hours tural',		3 Widowed 4 Divorced	Year or Dates:	16a, Deced	ent's Usual Occupa	ation	16	b. Kind of Busi	White ness/Industry			
215	C 9	piet	(Specify only highest gi	rade completed) College (1-4or 5+)	(Give I	rind of work done of OO NOT use retired	turing most of work)	ring	Constr	action			
	filed within Hygiene. other than "	Completed	ll Years		Dry	wall Mecl		(C)	Construction				
gue	othe	Be	17. Father's Name (First, Middle, Las Frank W. Willi					e (First, Middle, Maiden Sumame) L. Massey					
Maryland	s 1 and 2 should be f f Health and Mental I Itam 27 Is markad of other traumatic eve	2	19a. Informant's Name/Relationship		al Route Number, C		ate, Zip Code)						
	다 하는 다		Mrs. Edith Mass	ey / Mother	7823	St. Gre	gory Dri	ze Dundal	k, Mar	yland 21222			
Baltimore,	es 1 a of Hea if Itam or othe		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3	Bemoval from State	**	atory or other plac	θ)			ty or Town, State			
ţ	. Pag tment tant:		'4 ☐ Donation 5 ☐ Other (Spec	sify)				22/2004 1	Middle	River, MD			
Bal	20a. Meriod of Disposition 1												
П			23a. Part1. Enter the disease, or conshock, or heart failure. List only	y one cause on each line.	1.1		g, such as cardiac	or respiratory arrest		Approximate Interval Between Onset and Death			
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9	tificate ig phys as the	Physician/Medical		u					1				
Вох	Jeath certifica attending ph for use as th	an/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of p	Fetal death 3	Ectopic pregnancy			23d. Date	,			
.O.	ne dea the at thed fo	ysici	1 Yes 2 No	4□Pregnant at tim 9□Unknown	e of death 5□	Other (specify)				,			
Δ.	es that the de igned by the a be detached f		Part II. Other significant conditions			iderlying cause give	en in Part I.	23e. Did tobac	co use contrib	ute to the cause of death?			
rds	w requires been sign should be	ed by	End Stage Live	er Disease				1 🗆 Yes	2□No 3	Probably 4 Wiknown			
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of Vital	Physiclan: r this certificatal director,	To B	examiner? 1 🗆 Yes 2 No	Hospital: Inpatient	2 ER/Outpatien		4 Nursing H	ome 5 Residence					
o uc	ding Phys	:lon:	27. Manner of Death 1 Natural 5 Pending 2 Accident investigati	28a. Date of Injury (Month, Day Ye	28b. Time of Injury	28c. Injury Work M 1 □	/at k? Yes 2 □ No	28d. Describe how	injury occurred				
Division	Attanding in death. actor: After by the fune	ficat	3 ☐ Suicide 6 ☐ Could not	be age place of louing	- At home, farm, stre			28f. Location (Stree City or Town, S	et and Number	or Rural Route Number,			
Di	s after s after al Dire	Certification;	4 Homicide	building, etc. (S	эреспу)			City of Town, S	nate/				
	To the Hospital or Attanding Physician: within 24 hours after death. To the Funeral Diractor: After this certific completely filled in by the funeral director.	edical	29a. Certifier Check only one)	Physicien: To the best of m aminer: On the basis of ex- and manner stated	amination and/or inv	occurred at the time restigation, in my of	ne, date and place, pinion, death occui	and due to the caus red at the time, date	se(s) and manr and place, an	er as stated. d due to the cause(s)			
	To the To the comp	Me	29b. Signature and title of certifier	majile	, MD	29c. License	9784	29d	Date signed (Month, Day, Year) Ler 18,2004			
	B		30. Name and address of person who Cathlean F. May	o completed cause of death	h (Item 23a) (Type, opkins &	Print) Ayriew M	seascal C	ienter/	1940 1 Baltim	er 18,2004 Easterntvenue/ ore, MD 21224			
		ate	31. Date filed (Month, Day, Year)	32. Registrar's	Signature	1	1,						
	Regist	rar	NOV 2 2 2	2004 Dener	- K	spork	2						

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				1 = For State Registrar		Sid	ate of iv	larylari		artmer <i>rtifica</i> i				ental H	ygiene Reg. N		36992
		Physici		Decedent's Nam She	e (First, Mida eila	le, Last)			Willi	ame				2. Date of D Month	Da	Year	3. Time of Death
	7	/Medic Examir		4a. Facility Name (n, give street	and number	')	MITIT		Town, c	or Location	n of Death		15	2004 County of Deat	12:40p M
						-Timon						noniu		Balt			nore
		Funeral Director		5. Social Security N 213-60-5	622	6. Sex 1 ☐ M 2		ge (In yrs. I 52	ast birthday) Yrs.	If Unde Months	Days	If Unde Hours	er 24 Hrs. Min.	8. Date of Birth (Month, Pay, Year) 4-16-52		9. Birt	hplace (State or Foreign untry) Md.
		land		Usual Residence o 10a. State	f Decedent 10b. County	/		10c. City	, Town or Lo	ocation							10d. Inside City Limits
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		or 28	Director	10e. Street and Nu						1 Of. Zip	Code				10g. Ci	tizen of What Co	untry?
		eeth v	Funeral	935 413	St. Str		as Decedent	21218 Ever in U.S. 13. Was Decedent of Hispanic Origin? (S)					original (Con	-4. V N		USA	i a taria
р. Щ	36	72 hours after deeth with the Maryland Instural, or Itams 23s or 28s-f show disal Exactinat Itse Indified at	by Fun	1 Never Marr		ried Ar	med Forces' ∐Yes 2∭X Yes Give	? No		was Dece If Yes, spe 1 ☐ Yes	cify Cubi	an, Mexic	c Origin? (Specify Yes or No- kican, Puerto Rican, etc.)			14. Race - Ame Black, White Specify: D1	e, etc.
40	5-0036	2 hour		3 Widowed		nt's Education	ar or Dates:	1	16a. Decedent's Usual Occupation						16b K	ind of Business/	ack
171	21215	s 1 and 2 should be filed within 72 hours after deeth with the Marylar if Health and Mental Hyglene if Health and Mental Hyglene it Health are restricted other than "netural", or itams 23s or 28s-f show other treumatic event, the Medical Execution instables indiffed at	Completed	(Special Special only higher andary (0-12)	st grade com	pleted) ollege (1-4or	5+)	(Give kind of work done during most of working life. DO NOT use retired) Janitoral					g		/aries	industry	
4	b D	e filed al Hygi other	BeC	17. Father's Name	(First, Middle,	Last)					Lul	18. Moti	her's Name	(First, Middle			
7007	Maryland	ould b Menta	ToE	William								Elizab			Dorsey		
5	Mar	d 2 sh th and 7 is m treum		19a. Informant's N			,									or Town, State, Z	ip Code)
⊣ ≰		ages 1 and 2 and 0 and 0 and 0 and 0 and 1		Ronnell 20a. Method of Dis		Dā	aughte	20b. PI	ace of Dispo	sition (Nai	ne of	1	y Terr	ate Bal		ocation - City or	21217 Town, State
NOVEMBER		00		1 Burial 2 4 Donation			al from State	' .	metery, crer ng Men	-		ce)	11-22	2-04			own, Md.
1 0	Balt	permit. Pag Department Importent: I any injury o		21. Signature of Fu	ineral Service		-		- 1	. Name ar			ility	Balt	imor	e, Md.	21202
4		40.1.64		23a. Part1. Enter t	he disease, o	r complication	s that cause	d the death		March				1101	E. N	orth Av	Approximate
		Physician /Medical Examiner		Immediate Cause disease or condition resulting in death)	(Final on	a	BREAST	r CANC	CER								Interval Between Onset and Death
VI		e executed en and rial-transit	Examiner	Sequentially list co if any, leading to in cause. Enter Under Cause (Disease or that initiated events resulting in death)	erlying injury	{ '	Due to (or as	a consequ	ence of):								
	68760,	tificate be exe ng physicien a as the burial-	edical Ex										nur Stallies				
2	.O. Box (requires that the death certificate be teen signed by the ettending physicic hould be detached for use as the bu	hysician/Me	IF FEMALE: 23b. Was deceden in the past 12 1 Yes 2 9	months?	1C 4C	res, outcome Live birth Pregnant a Unknown	2 Fetal	death 3□	Ectopic pr Other <i>(sp</i>						23d. Date of deliv Month	rery Day Year
TITI I	rds, P	w requires that been signed b should be deta	by P	Part II. Other signif	icant conditi	ons contributi	ng to death b	out not resul	ting in the ur	nderlying c	ause give	en in Part	I.			se contribute to	the cause of death?
Try W.	l Rec	The law ate hes to page 2 si	Completed											24a. Was auto perfo 1 \(\text{Yes} \)		24b. Were aut prior to co death?	opsy findings available ompletion of cause of
3	Vital	Physicien: Th this certificate ral director, pag	Be	25. Was case refer examiner?		l Hospita	-				Oth			Check only	one)	1	
-	o	ing After une	lon: To	1 ☐ Yes 2 🔀 27. Manner of Death 1 🛣 Natural	h 5 🗌 Pendir	28a	. 1 ☐ Inpatie Date of Inju (Month, Da	iry :	P/Outpatien 28b. Time of Injury	2	8c. Injury Work	4∐N ∤at k?	28	e 5 Resi			h) HOSPICE
	5	or Atten after deal Director in by the	Certification:	2 Accident 3 Suicide 4 Homicide	investi 6 Could determ	not be	. Place of Inj building, et	ury - At hor c. (Specify)	ne, farm, stre	M eet, factory		Yes 2□		If. Location (City or To	Street and wn, State)	d Number or Rur)	al Route Number,
		Hospite 4 hours Funeral (aly filled	edical C	29a. Certifier (Check only one)	1X Certifyir 2⊟ Medical	exeminer: Of	To the best the basis of d manner sta	t examination	ledge, death on and/or inv	occurred estigation,	at the tim	ne, date ar pinion, dea	nd place, ar ath occurred	d due to the	cause(s) date and	and manner as s	stated. o the cause(s)
		To the Hos within 24 h To tha Fur completely	Me	29b. Signature and	title of certifie	1				29c	. License	e number			29d. Date	e signed (Month,	Day, Year)
				•	_ /	1					DU	137	25		/	1/151	04
		1		30. Name and addre								-				1	
		Sta	te	DR. TAK 31. Date filed (Mont			2300 I 32. Registr			LEY R	D	TIMO	NIUM,	MD 21	093_		
		Registra	200	NO	V 2 2 2	004	Street	mar	by	Lace	Kal	,					

DHMH 17 Rev 1/2001

ALTOF ZARTDINOV 04-6 dap

548	37		Please				lealth and Mental	_	oie.
		•	1 - For State Registrar	State of		rtificate of	Death	Reg. No 201	04 36993
	Physici /Medic		1. Decedent's Name (First, Middle, L. Altof Zartdir				Mont	of Death Day DBER 8, 200	Yeer 4 5:30a M
4	Examin		4a. Facility Name (If not institution, gi 7941 FOX CREST CO		oer)	4b. City, Town, or POTOMAC	Location of Death	4c. County of MONTGO	
	Funeral Director				Age (In yrs. last birthday, 63 Yrs.	If Under 1 Year Months Days	Hours Min. 8. Date (Mon May	of Birth th, Day, Year) 24, 1941	Birthplace (State or Foreign Country) Russia
	e Maryland a-f show	ctor	Usual Residence of Decedent	omery	10c. City, Town or L	ocation			10d. Inside City Limits 1 ☐ Yes 2√ No
	with the	Dire	10e. Street and Number 7941 Fox Crest 0	ourt		10f. Zip Code	854	10g. Citizen of W	
36	72 hours after death with the Maryland netural', or Items 23e or 28a-1 show disal Evaril writinal be truffiled at	by Funeral Director	11. Marital Status 1 □ Never Married 2 ☒ Married 3 □ Widowed 4 □ Divorced	12. Was Deced Amed Ford 1 Tyes 2 If Yes, Give	ĬNo		ispanic Origin? (Specify Yes an, Mexican, Puerto Rican, et Specify:		SA - American Indian, k, White, etc. - white
21215-0036		Completed b	15. Decedent's (Specify only highest g Elementary/Secondary (0-12) 1 2	Education rade completed) College (1-4	16a. Dece (Give life.	DO NOT use retired	durina most of working	16b. Kind of Bu	siness/Industry un
and 5.	s 1 and 2 should Health and Mer tem 27 Is marke other traumatic	To Be Co	17. Father's Name (First, Middle, Las Sartdin Zartdi		We	elder	18. Mother's Name (First, A	Middle, Maiden Sumam	e) un
Baltimore, Maryland		Ė	19a. Informant's Name/Relationship Alla Levin/daugh 20a. Method of Disposition 1 □ Burial 2 □ Cremation 3	(Type, Print) iter in 1. □Removal from Si	aW 1010 20b. Place of Disp cometery, cre	4 Meredit	h Avenue Silv	er Spring,	
Baltin	permit. Pages Department of Importent: If i any injury or once.		21. Si nature of Euneral Saluce Lice Ronal S		irector Š	2. Name and Addre tate Anat altimore,	ss of Facility Omy Board 655 MD 21201	W. Baltimo	ore Street
	Pnysician /Medical Examiner		23a. Patt 1. Enter the disease, or co shock, or heart failure. List onl Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate	a		ter the mode of dyin		tory arrest,	Approximate Interval Between Onset and Death
3760,	ate be executed hysician and the burial-transit	ilcai Examine	rany, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	r as a consequence of):				
.O. Box 68	The law requires that the death certificate its has been signed by the attending physpage 2 should be detached for use as the	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 Live bir	nt at time of death 5	□Ectopic pregnancy	,	23d. Date Mor	e of delivery hth Day Year
<u>α</u>	w requires that is been signed by should be deta	by	Part II. Other significant conditions	contributing to dea	ath but not resulting in the	underlying cause giv	en in Part I. 23e		ibute to the cause of death? 3 Probably 4 Unknown
Il Records,		Completed						autopsy performed? p	Vere autopsy findings available rior to completion of cause of eath?
Vital	Physician: Th this certificate ral director, pag	To Be	25. Was case referred to medical examiner? 1XXYes 2 \sum No	Hospital: 1 🗆 In	patient 2 ☐ ER/Outpatie	int 3 DOA Oth	26. Place of Death (Check	_	or (Specify)
sion of	ding After fune		27. Manner of Death 1 Natural 5 Pending 2 Accident investigat	28a. Date of		of 28c. Injur	y at k? Yes 2 10 No \$ 10 0	cribe how injury occurre	ed
Division	To the Hospitel or Attenwithin 24 hours after death To the Funeral Director: completely filled in by the	Certification:	3 Suicide 6 ☐ Could not determine	buildin	of Injury - At home, farm, s g, etc. (Specify)	2	No.	or Town, State) 101	er or Rural Route Number. tcx cveit ccult
	To the Hospitel or within 24 hours afte To the Funeral Dirac completely filled in the completely filled in the completely filled in the following the filled in the following the filled in the filled	Medical	29a. Certifier 1 ☐ Certifying ((Check only one)	Physician: To the ta aminer: On the ba and manne	sis of examination and/or i	tn occurred at the tir nvestigation, in my o	me, date and place, and due pinion, death occurred at the	to the cause(s) and mai time, date and place, a	nner as stated. Ind due to the cause(s)
•	To the I within 2 To the I complete	Me	29b. Signature and title of certifier	M. 1	H for	29c. Licens	e number CME	29d. Date signed OCTOBER	(Month, Day, Year) 8, 2004
-			30. Name and address of person wh	o completed cause	of death (Item 23a) (Type	, Print)			

State Registrar

J. L. LOCKE M.D.

31. Date filed (Month, Day, Year)

NOV 2 2 2004

32. Registrar's Signature

111 Penn Street, Baltimore, Maryland 21201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 004 36994 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Day Year Arcoraci November 18,2004 6:14 Virginia /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltinore

If Under 1 Year If Under 24 Hrs. Months Days Hours Min. (Month, Day, Year)

NOV. 21 19 University of Maryland Medical Center NIA 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 ☑ F Yrs. Director 217-22-7293 76 MD Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "naturel", or items 23a or 28a-f ehow other treumatic event, it a Madical Examinar must be notified at 1 Yes 2 No Directo Maryland <u> Anne Arundel</u> Pasadena 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8009 East Riverside Drive 21122 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours efter c Department of Health and Mental Hygiene. Importent: If Item 27 is marked other than "naturel", or Iten eny injury or other treumatic event, It a Medical Examinat once. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐XNo Specify: White Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 8 Homemaker Household 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Sylveater Weichert 2 Lola Tracey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8009 East Riverside Drive, Pasadena, MD 21122 August L. Arcoraci (spouse) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition 20c. Location - City or Town, State Nov. 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State `4 ☐ Donation 5 ☐ Other (Specify) Cedar Hill Cemetery Baltimore, Maryland 2004 21. Signature/of Funeral/Service Licens 22. Name and Address of Facility Stallings Funeral Home, P.A. 3111 Mountain Road, Pasadena, MD 21122 23a. Part 1. Enter the disease, or complication shock, or heart failure. List only one cause caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) infection **Physician** (sepsis /Medical Due to (or as a consequence of): **Examiner** Preumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner use as the burial-transit Due to (or as a consequence of): the attending physician Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Day 4 Pregnant at time of death Division of Vital Records, P.O. signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by leukemia 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown chronic myelogenous Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 2[] No 1 🗌 Yes 1 TYes To the Hospital or Attending Physicien: within 24 hours after death.

To the Funerel Director: After this certifica 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 1 Inpatient 2 2 ER/Outpatient 3 DOA 27. Manner of Death 1 ☑Natural 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: Injury investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) M. Dect, M. O P18572 November 18, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar Luke Deitz, M.D.

31. Date filed (Month, Day, Year)

22 South Greene Street

32. Registrar's Signature

Baltimore, Maryland 21201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hyginal [] [] For State Registrer Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month **Physician** Alexander 10:05 a ^M Christiana Showacre November 16 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Wilson Healthcare Center Gaithersburg Montgomery If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) June 28,1916 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Months Hours Days 1 □ M 2 🔀 F 88 Director 220-36-9277 Maryland Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 7 is marked othar than "neturel", or items 23e or 28e-f sho treumatic event, the Mouncal Examiner must be notified at 1 ☐ Yes 2 ☑ No Director Anne Arundel Annapolis 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21401 USA 1916 Thomas Drive Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2XX\o If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2XXNo Specify: White Specify: Completed by 3XXWidowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry nd Mental Hygiene. marked othar than Elementary/Secondary (0-12) College (1-4or 5+) Education Teacher 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 12 should be fi and Mental H Edgar Harrison Showacre Elsie Gerstell ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 4713 Manor Lane, Ellicott City, MD 21042 Duane Alexander (Son) othar 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 1 Burial 2 Cremation 3 Removal from State ö Department (Important: If Gerstell Family Cem. 11/20/2004 Keyser, West Virginia 4 Donation 5 Other (Specify) Injury 21. Signature of Funeral Service Licensee 22 Name and Address of Facility Hardesty Funeral Home, P.A. 23a. Part1. Enter the disease, 12 Ridgely Avenue, Annapolis, MD 21401 Part1. Enter the disease, or emplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician ASPIRATION /Medical Due to (or as a consequence of). Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner that the death certificate be executed burial-transit Due to (or as a consequence of): Completed by Physician/Medical the as IF FEMALE: esn 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnancy Dav Year ō in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) 4☐Pregnant at time of death detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. should be TENTION 1 Yes 2 No 3 Probably 4 Unknown INSUFFICIENCY 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed INEMIA 1 ☐ Yes 2 ☐ No certificate 2 No Physicien: Be 25. Was case referred to medical examiner? funeral director 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other 1 ☐ Yes 2 🗖 No 4 Viursing Home ٢ 5 Residence 6 Other (Specify) this 27. Manner of De th 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Distatural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Diractor: 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) by determined 4 T Homicide within 24 hours a ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier cai npletely 29c. License number 29d. Date signed (Month. Dav. Year) 29b. Signature and title of certifier

Registrar

State

P.0.

Division of Vital Records,

GEDRGIA

30. Name and address of person who completed cause of data (Item 23a) (Type, Print)

9801

32. Registrar's Signature

VEMURY

MERLYN

31. Date filed (Month

SILVER SPRING MD 20902

			For State Registrar	State of Mary		rtment of He			erze 0 0 4	36996
			Decedent's Name (First, Middle, Last).		-			2. Date of Death	<u> </u>	3. Time of Death
	Physicia		HAPPY E. A	DAME	111			Novem 6	Day 20 200	4 11:30 AM
	/Medic Examin		4a. Facility Name (If not institution, give st	reet and number)		4b. City, Town, or		Olding	4c. County of Deat	
	E X		NORTH ARUNDEL	1405017	TAL	GLEN	Burn	E	ANNE	ARUNDEL
	Funeral		5. Social Security Number 6. Sex		n yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month Day April 5	Year) 9. Birt	hplace (State or Foreign untry)
	Director		203-20-6923	W 2 F	66 Yrs.			April 5	, 1938 Pe	nnsylvania_
1 1	and		Usual Residence of Decedent 10a, State 10b, County	10	Oc. City, Town or Loc	ation				10d. Inside City Limits
	Aaryl f sho	٥	MD Anne Aru	inde1	Severn					1 ☐ Yes 2 🛣 No
1	death with the Maryland ms 23a or 28a-f show finust be neithed at	Director	10e. Street and Number			10f. Zip Code		10	og. Citizen of What Co	untry?
	3a or		1849 Quebec Street			21	144		US	A
	death	Funeral		2. Was Decedent Eve Armed Forces?	er in U.S. 13. W	/as Decedent of His	spanic Origin? (Spe n, Mexican, Puerto I	cify Yes or No-	14. Race - Ame Black, White	rican Indian,
0, 9	or its	-F	1 Never Married Married	1XXYes 2 □ No	1	☐ Yes 2 X No	Specify:	110411, 0101,		White
\sim 8	72 hours natural',	d by	3 Widowed 4 Divorced	Year or Dates: 1	956-78					
₹.	"natu	lete	15. Decedent's Educi (Specify only highest grade	ation completed)	(Give k	ent's Usual Occupa rind of work done d O NOT use retired;	lurina most of workii	ng 1	16b. Kind of Business/	Industry
72	within ene. than	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		an Lingui			Federal Go	vernment
d 2	filed Hygid othar ant, I	Be Co	17. Father's Name (First, Middle, Last)				18. Mother's Name			
and Im	lid be lental kad c	To B	Harry E. Adams II				Madeline	Troutma	an	
\times \lesssim Mary	2 should be filed with and Mental Hygiene is markad othar tha aumatic avant, Iber		19a. Informant's Name/Relationship (Typ	e, Print)	19b. Mailing	Address (Street a	and Number or Rura	l Route Number,	City or Town, State, 2	lip Code)
	s 1 and 2 should be filed within if Health and Mental Hygiene. Item 27 is marked other than other traumatic avant, the Me	11 8	Lucille A. Adams (· · · · · · · · · · · · · · · · · · ·			treet, Se			
Adam Saltimore, Ma	iges 1 and 2 should be filed within 72 hours after death with the Marylan nt of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Madical Examer must be retified at		20a. Method of Disposition 1 ☐Burial 2 ☐ Cremation 3 ☐ Re	I	20b. Place of Dispos cemetery, crem	ition (Name of atory or other place	a) D	ate 2	20c. Location - City or	Town, State
O E	permit. Pages Department of mportant: If It any injury or o		*4 □ Donation 5 XOther (Specify)	Intombment]				/2004	Sunbury, P.	A
Balt	permit. Pa Departmer mportant: any injury		21. Signature of Funeral Service Lisense	-	22. H	Name and Addres	s of Facility Funeral H	lome, P.	Α.	
	707 # 0		23a. Part1. Enter the disease, or complic						A. lis, MD 21	401 Approximate
			shock, or heart failure. List only one	cause on each line.	e death. Do not ente		1	r respiratory arre	rst,	Interval Between Onset and Death
	Pnysician /Medical		Immediate Cause (Final disease or condition resulting in death)	- Hemi	orrhagi	C Shi	selc			Hours
	Examiner			Due to (or as a c	consequence of	dan	al Anc	tic Ar	CUANA	1 day
	15 638	ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a c	consequence of):	CUOTAT	01 1 101	1.6711	0019/31-	· · · · · · ·
	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events							,
oʻ	an and rial-tra		resulting in death) Last	Due to (or as a c	consequence of):					
8760,	cate be executed physician and the burial-transit	dicai	d.							
9	artifica ing pt	Med	IF FEMALE:							
Вох	The law requires that the death certificate has been signed by the attending Is age 2 should be detached for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months?	c. If yes, outcome of 1☐Live birth 2 [Fetal death 3	Ectopic pregnancy			23d. Date of del Month	ivery Day Year
o.	the a	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at tim 9□Unknown	ne or death 5 □	Other (specify)			1	
P.O.	that the		Part II. Other significant conditions conf	nbuting to death but r	not resulting in the un	derlying cause give	en in Part I.	23a. Did tob	acco use contribute to	the cause of death?
ds,	uires sign ld be	d by	Respirator	1 Fail	200			1 ☐ Ye	s 2 ,5€ No 3 □ Pr	obably 4 Unknown
Sor	w requ	lete		(24a. Was ar	24b. Were au	topsy findings available
Re	he lay e has ige 2	Completed						autopsy	prior to death?	topsy findings available completion of cause of
酉	sician: The law certificate has b irector, page 2 s		25. Was case referred to medical				26. Place of Death		P.110	2 (S-N 0
Division of Vital Records,	Physician: r this certific ral director,	o Be	examiner?	spital:	2 ER/Outpatient	3□ DOA Othe			nce 6 Other (Spe	cify)
0	ding Phys n. After this funeral di	n: T	27. Manner of Death	28a. Date of Injury (Month, Day Y	28b. Time of	28c. Injury Work	at (?	28d. Describe ho	w injury occurred	
io	andin sath. or: Af he fur	atic	1 Matural 5 Pending 2 Accident investigation				Yes 2 □No			
<u> </u>	r Attu ter de iracto iracto	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury building, etc. (· At home, farm, stre (Specify)	et, factory, office		28f. Location (Str City or Town	reet and Number or Ru , State)	ıral Route Number,
Ω	urs af									
	To the Hospital or Attanding Physician: The within 24 hours after death. To tha Funaral Director: After this certificate his completely filled in by the funeral director, page	Medical			kamination and/or inv				tuse(s) and manner as ate <i>a</i> nd place, and due	
	o the ithin (o tha	Mec	29b. Signature and title of certifier	und manner states	J	29c. License	number	29	d. Date signed (Monti	h, Day, Year)
	F > F 8		Mario Oan	10		200	32744	1 1	nula mahar	20 2004
			30. Name and address of person who cor	npleted cause of dear	th (Item 23a) (Type. I		70 ()	T	vvem xx	20 2004
/	10		301 Hospital T	dive 1	11	vnic	MD	MAR	SIA GAV	IRIA
A	Sta	ate	31. Date filed (Month, Vay, Year)	32. Plogistrar's	s Signature	house to	/			
	Regist	rar	NOV 2 3 2004	100	14	the market				

State of Maryland / Department of Health and Mental Hygiens 36997 Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Physician William Wilton 5:45A M NOVEMBER 20 2004 /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** North Arundel Hospital Glen Burnie Anne Arundel If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) March 26, 5. Social Security Number 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country)
 MD 6. Sex **Funeral** Min. XXM 2□F Months Days Hours 579-38-9876 75 Director Usual Residence of Decedent 10c. City. Town or Location 10b. County 10a State 10d. Inside City Limits ral', or Itams 23a or 28a-f shov Evantiber must be notified at 1 ☐ Yes 2 No MD Gambrills Director Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2126 Old Dairy Farm Road 21054 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 XYes 2 No 194 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status Black, White, etc. 1948-1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes XXNo Specify: 1950 3 ☐ Widowed 4 ☐ Divorced Year or Dates White netural Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) other traumatic event, It's Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiena. College (1-4or 5+) Elementary/Secondary (0-12) 12 Printer Graphics Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be nd Mental F William Lesley Butler Ella Cooley 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health tem 27 Josie G. Butler / wife 2126 Old Dairy Farm Road, Gambrills, MD 21054 Hem Department of H Important; If iten any Injury or othe once. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Nov. 23, 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Maryland Veterans Cem. A □ Donation 5 □ Other (Specify) Crownsville, Maryland 21. Signature of Funeral, Service Licensee 22. Name and Address of Facility Singleton Funeral Home, P.A. Tark MO1357 Vanuere 1 Second Ave. SW, Glen Burnie, MD 21061 23a. Part 1. Extensive disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) CALLUCE Physician CONGESTIVE HETTET /Medical Due to (or as a consequence of): **Examiner** PULLUDNARY MICHSE OBSTRUCTIVE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be exacuted burial-tran Due to (or as a consequence of) Box 68760, physician Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Pol Month Year Day 4 Pregnant at time of death 5 Other (specify) P.O. I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an certificate has birector, page 2 s 20 No 1 Yes Hospitel or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After 1 Natural s after de. ral Director: Ahr 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours al To the Funeral D completely filled i 29a. Certifier l 🔾 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) offe) and manner stated the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Dav. Year) beleke Kassahun M.D. 00055973 NOUTMBER 20,2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 11500 SILVER SPLING SUTHERLAND WALL DE SSE 32. Registrar's Signature State Registrar

Attending Physicien: The law requires thet the death certificete be executed Box 68760. as P.O. Records, certificate of Vital Division death. Director: A or A efter

36998 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3 Time of Death NOV. 20, Day 2004 **Physician** Year 12:46 P.M. CELESTE E. BLOCKSTON /Medical 4b. City. Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner CHRISLEIGH ASSISTED LIVING GAMBRILLS ANNE ARUNDEL 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Yea APR. 3, 1 5. Social Security Number 6. Sex 9. Birthplace (State or Foreign **Funeral** 1□ M 2 F Months Davs Hours Min. 85Yrs. 1919 MARYLAND 212-03-3820 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No LANSDOWNE Directo MARYLAND BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 162 HOWARD AVE. 21227 UNITED STATES Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: WHITE þ 3 Widowed 4 □ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) SALES CLERK RETAIL SALES 10 filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be 1 nent of Health and Mental I int: If Item 27 is marked of JOSEPH HOWARD STRIDER ELLEN STEWART 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 533 BRIGHTVIEW DR., MILLERSVILLE, MD 21108 RODNEY H. BLOCKSTON / SON 20b. Place of Disposition (Name of cemetery, crematory or other place) NOV. 22 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State permit. Page Depertment of Important: If BROOKLYN PK., MARYLAND CEDAR HILL CEMETERY 4 Donation □Other (Specify) 21. Signatur al Service Dicense KIRRLEY ACCOUNTION FUNERAL HOME, P.A. 421 CRAIN HWY., S.E., GLEN BURNIE, MD 21061 ©) 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Physician /Medical Immediate Cause (Final a advanced dementia years disease or condition resulting in death) Examiner Examine physiclan and s the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown þ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? 2 X No 1 ☐ Yes 2 ☐ No 1 ☐ Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify LIVING Hospital: 1 Inpatient 1 Yes 2 No Certification: To 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending investigation 1 | Yes 2 | No 2 ☐ Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide To the Hospital within 24 hours e 1th Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier and manner stated 29b. Signature and title of dertifier 29c. License number 29d. Date signed (Month, Day, Year) D 50725 NOVEMBER 22, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) b JENNIFER RIEDINGER, M.D., 8601 VETERANS HIGHWAY, SUITE 204, SEVERNA PK., MD 21401 32. Regintrar's Signature 31. Date filed (Mont)

State Registrar

State of Maryland / Department of Health and Mental Hygiene) 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** NOV. 20, 2004 10:40pBessie R. Barrack /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 508 Hill Street Mt. Airy Frederick If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year) JAN. 17, 1924 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1□M 2√2F Months Days Hours 192-18-5823 80 Pennsylvania Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examinar must be notified at 1 ☐ Yes 2√2 No Director Maryland Frederick Mt. Airy 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? With 508 Hill Street 21771 USA death by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 2 should be filed within 72 hours after of and Mental Hygiene. Is marked other than "natural, or iter 1 Types 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 Yes 2 No Specify: White Baltimore, Maryland 21215-0036 Specify. 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Domestic 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) William Reilly Beulah Miller 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If Item 27 is m any injury or other traum onct. Melissa Eakle/daughter 508 Hill Street Mt. Airy MD 21771 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Metro Crematory, Inc. 11/23/04 Baltimore, MD ^ 4 □ Donation 5 □ Other (Specify) 21. Signatur of Juneral Service License. ²², Name and Address of Facility Cremation Society of Maryland, 299 Frederick Road Baltimore, Dawn F. McDonald

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician (on CESTIUE 3 MONTIS /Medical Due to (or as a consequence of) **Examiner** 4 HAR UENTO Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine certificate be executed MITTAL burial-tran Due to (or as a consequence of): P.O. Box 68760, attending physician for use as the burial Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 Ø No Month Day Year 4 Pregnant at time of death 5 Cher (specify) ed by the a 9 Unknown is been signed by the should be detached Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 ☑ No 3 Probably 4 Unknown Completed 7 () 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy 2D No Yes To the Hospitel or Attending Physicien: : After this certifical funeral director, p 25. Was case referred to medical Be 26. Place of Death (Check only one, examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending Injury 24 hours after death. Funerel Director: Al 1 Tes 2 No investigation 2 Accident 3 🗌 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) within 2-29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier who completed cause of death (Item)23a) (Type, Print) CENTER ST. #209 MT. AMMY, MO P 32/Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

State of Maryland / Department of Health and Mental Hygiene 004 37000 For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Year Physician 9:00A M PEARI BEALE 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner NIA BALTIMORE N. ELLAMONT STIZEET If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day) **Funeral** Months 1 M 2 DE Days Hours 80Yrs Director 227-44-1361 Usual Residence of Decedent 10c. City, Town or Location 10d Inside City Limits 10b. County 10a. State item 27 is marked other than "natural", or Items 23s or 28s-f show other traumatic event, the Madical Examinar must be notified at MD BALTIMORE 1 ☑Yes 2 ☐ No Director 10f. Zip Code 10g. Citizen of What Country? 1800 N. ELLAMONT STREET 21216 U.S.A. by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc 1 □ Never Married 2 □ Married 1 Yes 2 No Specify: BLACK 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 12 should be filed within 7. h and Mental Hygiene."n: 7 is marked other than "n: College (1-4or 5+) lead Deale Elementary/Socondary (0-12) PRIVATE HOMEMAKER 7th grade 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) BLACKWELL DAVID THOMPSON BUHLER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 s nent of Health an Department of Health at Important: If item 27 is any injury or other training once. 2521 ARUNAH AVENUE BALTIMORE, MD 21216 JUDITH MAYO/COUSIN 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☑Cremation 3 ☐ Removal from State BALTIMORE, MD GREENMOUNT 11.22.04 ^ 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licens 22. Name and Address of Facility CREMATION SERVICES 5151 BALTIMORE NAT'L PIKE BALTO. MD 21229 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death aceiden Immediate Cause (Final Cocon under **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Due to (or as a consequence of): Sequentially list conditions Examiner cause. Enter Underlying Cause (Disease or injury ed by the attending physician and detached for use as the burial-transit requires that the death certificate be executed your that initiated events resulting in death) Last Due to (or as a c sequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year Month 4 Pregnant at time of death 5 Other (specify) 9 Unknown certificate has been signed by rector, page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1 ☐ Yes 2⊞ No 25. Was case referred to medical 26. Place of Death (Check only one) examiner Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 910 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred Certification: 27. Manner of Death To the Hospital or Attending 5 Pending investigation 1 Natural death. 1 Yes 2 No 2 Accident Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a Funeral L 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely (Check only one) within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier MD 11/18/04 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Entow St Ente 308 Ball (+ASAMI 82(N. MID 31. Date filed (Month, Day, Year) 32. Posistrar's Signature State Registrar NOV 2 3 2004